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MISSOURI GOVERNOR'S TASK FORCE ON HEALTH CARE COSTS

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Contents

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BARRETT A. TOAN
DIRECTOR

December 13, 1984

The Honorable Christopher S. Bond
Governor of Missouri
State Capitol Building
Jefferson City, Missouri 65101

Dear Governor Bond:

We are pleased to present the report of the Task Force on Health Care Costs. The report reflects the Task Force's deliberations during the last six months. While the background of the Task Force is diverse — business, labor, the insurance industry, hospitals, doctors and consumers were all represented on the Task Force — we were able to agree on both a general approach and specific measures to help contain the rapid increase in health care costs.

Our report recommends that pro-competitive market forces will, if given a chance, bring health costs under control in Missouri. Today, much of the health care system is not subject to competitive market forces. State government, the business community and health providers need to work together to instill marketplace competition in health care. The recommendations contained in this report are steps in this direction.

A competitive approach offers the best hope for Missouri to maintain affordable health care in the years to come.

Sincerely,

Lee Liberman
Co-Chairman

John Kreamer
Co-Chairman

Phil Hutchison
Fred Speckmann
James Henry MacDonald
John Craft
Albert P. Mauro
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Executive Summary

Health care has become increasingly expensive. In 1983, some 10.8 percent of our national economy was devoted to health care, compared to 9.5 percent in 1980, only three years before, and 6.0 percent in 1965. The cost of health care in Missouri is among the highest in the country. For example, expenses per capita for inpatient hospital services are the third highest among the 50 states. These high costs result in higher out-of-pocket medical expenses than are necessary, higher insurance premiums, and higher taxes to support such programs as Medicaid and to pay for health insurance benefits for employees of state and local government.

Fortunately, change has already begun to occur. Private employers are redesigning their health benefits to make employees more conscious of costs. Providers have become increasingly sensitive to cost issues and are responding in constructive ways. New systems of care that incorporate incentives for efficiency, such as health maintenance organization (HMOs), are growing in numbers and enrollment. The State is also taking action, such as by reforming its Medicaid program, redesigning its health benefits program for its employees, and rewriting the State Health Plan.

Nonetheless, much more needs to be accomplished. The Task Force believes that the fundamental problem is the lack of a sufficient marketplace discipline for both consumers and providers. This root problem needs to be addressed, primarily through private sector initiatives. However, the State also has important roles to play -- by acting as a prudent purchaser for its own health programs, by promoting the availability and dissemination of information necessary for sound decision making by all concerned, and by continuing to impose certain constraints on providers during a transitional period until effective marketplace incentives are in place.

The philosophy of the Task Force is reflected in the recommendations that are presented in this report. They fall into three areas: (1) health care financing, (2) control of health system capacity, and (3) data and utilization of services. The major recommendations under each are summarized in the following pages.

Health Care Financing

- Health insurance plans should incorporate appropriate patient cost sharing and other provisions to limit unnecessary care. At the same time, they should incorporate adequate protections against financially catastrophic illness.
- Both the State and the private sector should encourage the continued development of competing alternative delivery systems.
- All parties need to be concerned that cost containment efforts do not reduce access for indigent populations. Federal, State, and local governments have the primary responsibility in this regard, with philanthropy playing a supportive role.
- Rising malpractice insurance premiums have contributed to rising health care costs, and State legislation is needed to address this problem.

Control of the Capacity of the Health Care System

- Information should be readily available on overall community hospital use and individual hospital prices and volume in order to foster rational decision-making regarding the need for inpatient facilities.
- Hospital trustees should become more involved in formulating responses to declining hospital use.
- The existing legislative moratorium on hospital and nursing home construction should be continued, and the process for granting certificates of need for new facilities and services should be strengthened.

Data and Utilization

- Legislation should be enacted to require that hospitals and physicians adopt a uniform bill and that third party payors accept this bill.
- Hospitals, physicians, and other independent practitioners should be encouraged to disclose prices for commonly provided services.
- Private purchasers and third party payors should ensure that they have effective utilization review efforts in place.

List of Recommendations

1. Health insurance plans should avoid first-dollar coverage but should also incorporate adequate protections against financially catastrophic illness.They should also incorporate other provisions to limit unnecessary medical care, such as promoting second opinions for surgery, requiring prior certification for non-emergency hospital admissions, promoting alternatives to inpatient treatment, and retaining cost sharing for persons covered under more than one policy.
2. Both the State and the private sector should encourage the continued development of competing alternative delivery systems, such as HMOs and selective contracting arrangements.
3. All parties need to be concerned that cost containment efforts do not reduce access for indigent populations. However, the responsibility of financing care to such populations rests primarily with federal, State, and local governments, with philanthropy playing a supportive role.

4. Missouri law affecting medical malpractice should be amended to:
   - Grant the defendant or the plaintiff the right to require structured payment of awards, that is, payment in installments over several years rather than as single lump-sums.
   - Place limits on the portion of awards attributable to non-economic loss.
   - Prevent double recoveries by plaintiffs from multiple awards from sources such as health insurance, workers' compensation and malpractice judgments.
   - Permit the courts to apportion recovery among multiple defendants, based upon comparative fault.
   - By means of a graduated scale, limit the size of contingent attorneys' fees as a proportion of plaintiffs' awards.
   - Authorize summary judgments in cases where there are no factual disagreements.

   In addition, the State should investigate the possibility of instituting a voluntary binding arbitration system.
5. In the current environment of rapidly rising health care costs, the State should avoid mandating new benefit expansions on the private sector.
6. The State should ensure that information on overall community hospital use and individual hospital volume is analyzed and disseminated.
7. Hospital trustees should become more involved with business coalitions in formulating appropriate responses to declining hospital use and in identifying opportunities for merger or consolidation and changes in their respective hospital's role in the community. To assist trustees in playing this role, the State and private groups should conduct information programs for trustees on the changing hospital market.

8. The moratorium on hospital and nursing home development should both be continued and expanded to include specific services.
9. The legislature should amend the certificate-of-need statute to expand participation by purchasers and consumers and to tighten the standards for project approval.
10. The following two topics should be the subject of further study.
    - Whether a mechanism should be established to assist institutions in financing closures and mergers;
    - Whether institutional access to tax exempt revenue bonds should be restricted.
11. Legislation should be enacted to require that hospitals and physicians adopt a uniform bill. Payors should be required to accept the bill for payment purposes.
12. Hospitals should calculate and publicly disclose average per case charges for up to twenty-five diagnostic categories. Similarly, physicians should be encouraged to develop and make available upon request price lists for their most common procedures. Those who purchase care should insist on such information being readily available.
13. The State should publish, or assure that all purchasers have access to, both (1) data that compares individual provider's prices and utilization characteristics and (2) data on utilization patterns by geographic areas, such as counties or regions, that represent medical service areas.
14. Private purchasers and third party payors should ensure that they have utilization review efforts in place.
15. Legislation should be enacted to protect the confidentiality of written peer review records.

I. INTRODUCTION

The medical advances of the last twenty years have been enormous. New diagnostic procedures facilitate the identification of disease and are less invasive to the body. New surgical procedures are safer and require less time for the patient to recover. In addition, insurance coverage, both public and private, is more widespread. This, combined with the increasing supply of health professionals, who are better trained than ever, has eased the fear of financial ruin due to illness and improved access to care. In sum, we are living longer and healthier lives than ever before.

This progress, however, has been accompanied by rapid increases in health care costs. In 1965, 6.0 percent of our national economy was devoted to health care expenses. This percentage rose to 9.5 percent in 1980 and reached 10.8 percent in 1983. Between 1978 and 1983, health care expenses per capita rose an average of 12.2 percent a year, 5.5 percentage points faster than the annual per capita growth in gross national product.[1]

Missouri, with its six medical schools and its fine teaching and community hospitals, has been at the forefront of the medical progress that has been achieved. However, our health care costs are also among the highest in the country. For example, Missouri has the third highest hospital costs per capita among the 50 states in the United States. It also has 5.5 beds per 1,000 population, 25 percent above the national average. Extra beds result in higher fixed costs than are necessary and can also encourage questionable use of services.

The impact of allowing this situation to persist is significant. High health care costs affect what we pay out-of-pocket for medical care. These costs are also reflected in insurance premiums and result in higher taxes to support vital public programs, such as Medicaid, and to provide health insurance benefits for employees of state and local governments. Furthermore, the higher premiums that private employers face for health

[1] All national health expenditures data in this report are from: Robert Gibson, et al. "National Health Expenditures, 1983." **Health Care Financing Administration.** vol. 6, no. 2, Winter 1984.

insurance either limit the monies available for wage increases or result in higher prices or lower profits. This, in turn, affects the economic base of the state, including reducing job opportunities, since high health care costs, like taxes, can influence decisions of corporations regarding whether to locate here. As illustration, McDonnell Douglas in St. Louis competes for business with Boeing in Seattle and faces higher premiums because hospital expenditures per capita are 60 percent higher in St. Louis.[2] A recent survey of employers in St. Louis found that per employee health care costs rose at an annual compound rate of 16.3 percent between 1979 and 1983.[3]

Something can be done. Furthermore, the rate of escalation in health care costs can be reduced without negatively affecting quality of care. Much medical care by its very nature carries some risk, however minimal, and unnecessary care can be harmful.

The private sector and the state have already taken significant steps. Employers, unions, and carriers have begun to redesign benefits, to review the necessity of inpatient services, to promote care in ambulatory settings, and to encourage the growth of alternative delivery systems. The benefits plan for state employees has been redesigned to increase patient sensitivity to costs. The state's Medicaid program has been changed, for example, to increase beneficiary copayments and to provide incentives to hospitals to contain costs. In addition, Missouri is one of a handful of states that has received demonstration waivers from federal Medicaid laws that have allowed it to enter into innovative contracts with competitive delivery systems.

[2] All hospital data in this report that are not service specific come from: American Hospital Association. **Hospital Statistics.** 1983 ed. Chicago: American Hospital Association, 1983.

Population data necessary to calculate per capita measures are from Bureau of the Census, "Estimates for the Population of States: July 1, 1981 to 1983." **Current Population Reports.** Series P-25, Number 944. Washington, D.C.: U.S. Department of Commerce, January 1984.

[3] St. Louis Area Business Health Coalition. **Health Benefits and Cost Containment in St. Louis: A Survey of the Membership of the St. Louis Area Business Health Coalition,** July 1984.

Both the state and the private sector have responsibilities. Importantly, the private sector also has much of the expertise and capacity to devise new and effective approaches. As a result, Governor Christopher S. Bond, last July, appointed a Task Force to analyze the problem and propose solutions. The Task Force includes representatives from business, unions, the insurance industry, and consumer and provider groups.

This report reflects the deliberations of that Task Force. Four chapters follow. The next chapter analyzes in more detail the nature of the problem in Missouri. The three chapters after that present and discuss the Task Force's recommendations. These recommendations, taken together, constitute a strategy to;

- alter the financing of medical care (discussed in Chapter III);
- address the problems of excess capacity, e.g., the surplus of hospital and nursing home beds (discussed in Chapter IV); and
- improve the availability of data necessary for sound decision making and promote processes to review the necessity of medical services (discussed in Chapter V).

Each of these three chapters consists of a background section, a list of principles that the Task Force has endorsed, and a discussion of the recommendations.

Different states have approached cost containment in varying ways. Underlying the recommendations of the Task Force is the belief that effective cost containment in Missouri can best occur by promoting a market place discipline. Such a discipline entails appropriate actions by purchasers, third party payors, consumers, and providers that foster marketplace competition. New and cumbersome layers of bureaucracy would be counterproductive.

However, the state does have important roles to play. The Medicaid and state employee benefits programs make it one of the largest purchasers of care. Through legislation, the state can help to assure that competition among providers occurs and that data necessary for private

decision-making are available. The state can assure that cost containment efforts do not hurt those without coverage. Finally, the state can document standards through its State Health Plan which, in turn, can be used to guide state regulatory actions and health promotion efforts in ways consistent with cost containment while ensuring quality.

Cost containment is neither easy nor painless. However, many traditional ways of financing and delivering health care cannot persist. Through the combined efforts of the many parties that have a stake in the outcome, we can succeed. The Task Force hopes that its recommendations represent a step toward an affordable system that preserves the values of quality, access, and innovation that we all cherish.

II. MISSOURI'S HEALTH COST PROBLEM

As part of its deliberations, the Task Force reviewed substantial amounts of information in order to understand the extent and nature of the health care cost problems in Missouri. The recommendations in this report reflect this analysis. Therefore, before presenting these recommendations, the Task Force wants to share some of the background information that underlies its view that public and private actions are required.

There are a number of reasons why per capita health care costs have been increasing so rapidly. First, the age distribution is changing, and the aged use many more services than the non-aged. Between 1965 and 1982 the proportion of the Missouri population over age 64 increased from 11.7 percent to 13.5 percent. Also, the proportion of children (with ages below 18) decreased from 34.6 percent to 26.7 percent.[4]

Another reason is changes in technology. New procedures and improved equipment allow the medical profession to do more, but often at greater expense. Estimating the contribution of technological change to increased costs is difficult. However, there is evidence that the introduction of major new technologies, while significant, has less impact than does greater use of "small ticket" items -- physician office visits, routine diagnostic procedures, and so forth. As illustration, if the annual operating costs for four of the nation's most expensive technologies -- CT scanning, electronic fetal monitoring, coronary bypass, and renal dialysis -- were reduced by half, health care expenditures would decrease by only one or two percentage points. As another illustration of how increases in the use of relatively routine services can add to costs, the number of laboratory tests has risen at an average annual rate of 10 percent over the last decade.[5] **The foremost reason for historical increases in health care**

[4] U.S. Census Bureau, **Current Population Reports,** Series P-25. nos. 384 and 930. Washington, D.C.: U.S. Department of Commerce, February 1968 and April 1983.

[5] Robert J. Blendon and Drew E. Altman, "The Cost of 'Little Ticket' Technologies," **Business and Health,** July/August 1984, vol. 1, no. 8, pp. 12-16.

costs, however, is that medical services are not subject to the same market discipline as most other goods and services. This lack of market discipline stems primarily from the existing system of insurance coverage, both private and public, under which the consumer is largely insulated from the economic consequences of his or her decisions. Furthermore, only rarely does either the party paying the premiums or the insurance company exert significant leverage on health care consumption or otherwise act as a prudent purchaser. As a result, competition among providers has generally not occurred on the basis of price or the efficient utilization of services.

Further fueling rising health care costs is the increase in physician supply. Unlike the market for most goods and services, physicians can, at least to some degree, generate demand for their services, particularly when most of the bill is paid by insurance rather than by the consumer. Nationally, between 1971 and 1981, the number of physicians per 100,000 population rose from 150 to 194 and is expected to reach 263 by the year 2000. In 1981, Missouri had 186 physicians per 100,000,compared with 142 in 1971. However, importantly, many rural areas still lack adequate numbers of physicians, with 12 counties in the state not having any.[6]

Most cost containment programs focus on restraining increases in hospital expenditures, because they represent the largest single item of expense. However, many other services have experienced increases of comparable magnitude. For example, nationally, between 1978 and 1983, whereas expenditures for hospital services rose at an average annual rate of 14.2 percent, nursing home services increased at a rate of 13.6 percent and physician services at 14.0 percent, hardly large differences.

[6] Unpublished data from the Bureau of Health Professions, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.

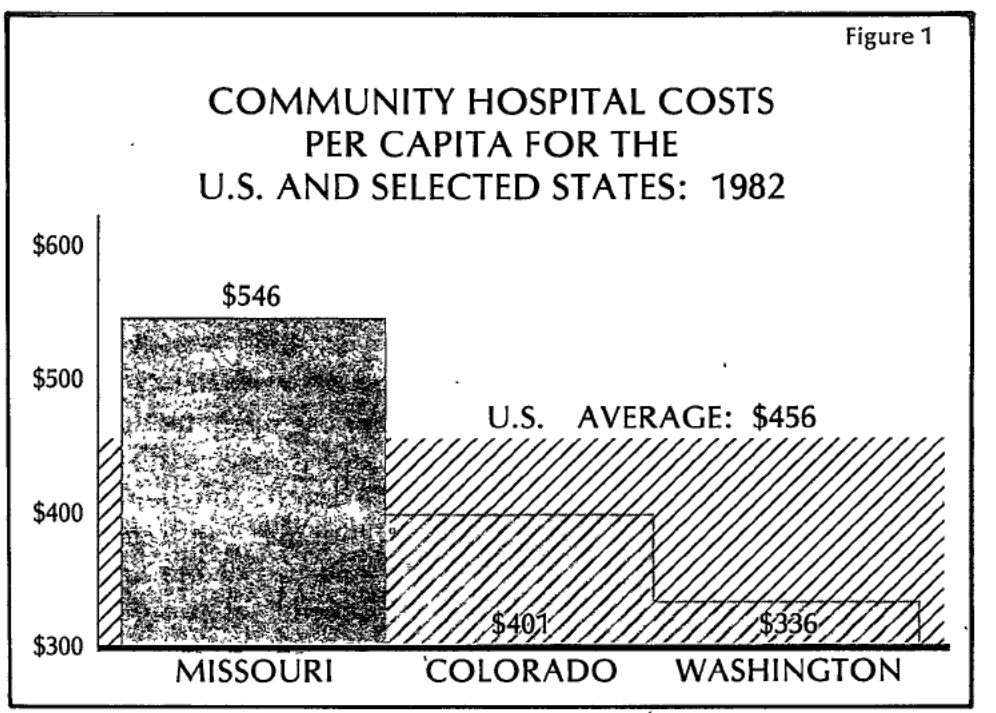
American Medical Association, **Physician Characteristics and Distribution in the U.S.**, 1982 ed., Chicago: American Medical Association, 1983.

Numbers reported here differ from data reported by the Missouri Center for Health Statistics. However, to assure comparability to national data, a national source was used.

Health care costs in Missouri are high and rising rapidly. In 1983, health care expenditures in the U.S. totaled $335.4 billion, or $1,459 per capita. Recent data for Missouri's total health care spending are not available. However, based on past experience, Missouri's per capita health expenditures are slightly above the U.S. average. This would indicate that between $7 billion and $8 billion was spent on health care in our state in 1983.

The national average reflects a mix of the experience of states with both higher cost and lower cost health care systems and is itself widely viewed as excessive. Thus, in addition to comparing with national data, it is useful to compare Missouri with other states that have less costly, more efficient, and more competitive health care systems. The states selected

Figure 1



for this purpose are Colorado and Washington. We have also, selectively, included data on some of Missouri's neighboring states

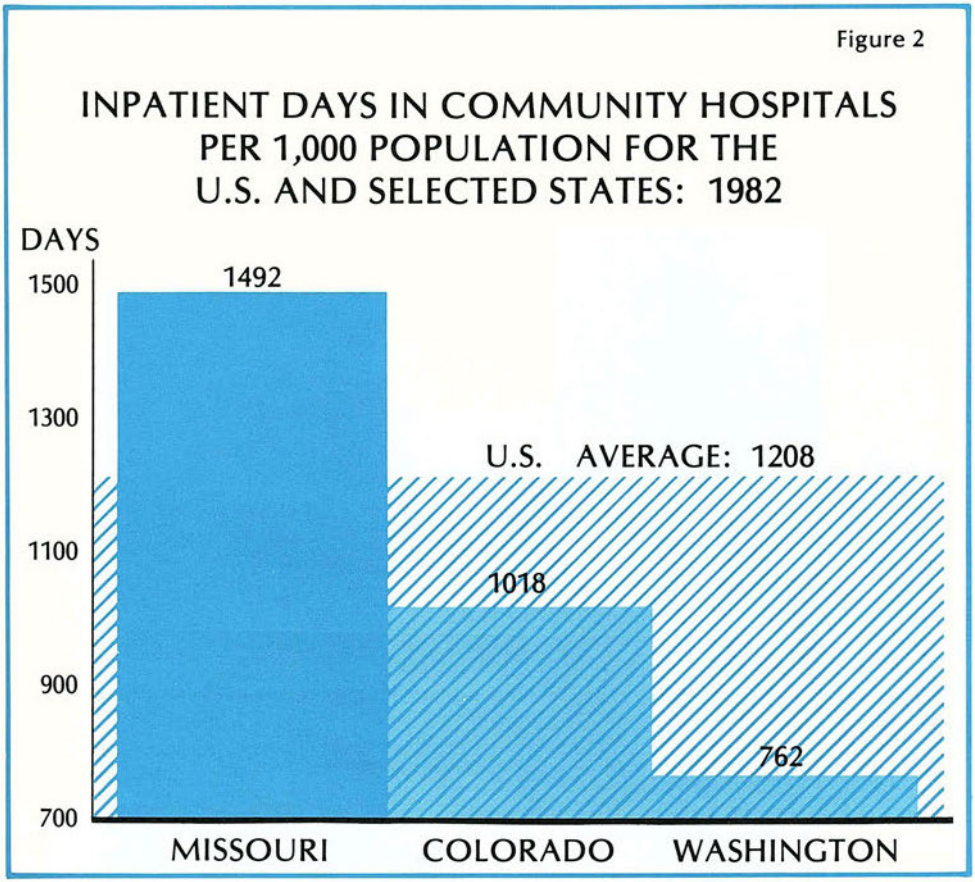
Unfortunately, recent state-specific (as opposed to national) data are not available on *total* health expenditures. However, they are available on *hospital* expenditures. In 1982, Missouri had the third highest community hospital cost per capita among the 50 states; only Massachusetts and Illinois were higher. Missouri's hospital expenses per capita of $546 is 20 percent higher than the U.S. average, and 36 and 62 percent higher than Colorado and Washington, respectively (Figure 1).* If Missouri lowered its 1982 hospital expenses to the level of the state of Washington, the savings would have exceeded a billion dollars. Other than Illinois at $564 per capita, other neighboring states have lower costs. For example, per capita hospital costs in 1982 were $446 in Kansas, $430 in Iowa, and $350 in Arkansas.

Total spending is a function of both how much health care is used and the price of individual services. Utilization of hospital and nursing home services is particularly high. Missourians in 1982 used 1,492 days of inpatient hospital care for every thousand people (Figure 2). This use rate was the fifth highest among the 50 states and was 24 percent higher than the U.S. average. It was 47 percent higher than in Colorado and nearly double that of Washington. Missouri is also somewhat higher than most of its neighboring states, vis-a-vis, Illinois at 1,353 days per 1,000 population, Iowa at 1,451, Kansas at 1,397, and Arkansas at 1,237.

Some have questioned whether this higher use might be due to the state's having a high percent of elderly. However, analyses to adjust the data on hospital use to reflect differences in age distributions demonstrate that this factor accounts for only part of the higher use: one-fourth of the difference between Missouri and the U.S., one-half of the difference between Missouri and Colorado and one-seventh of the difference between Missouri and Washington.

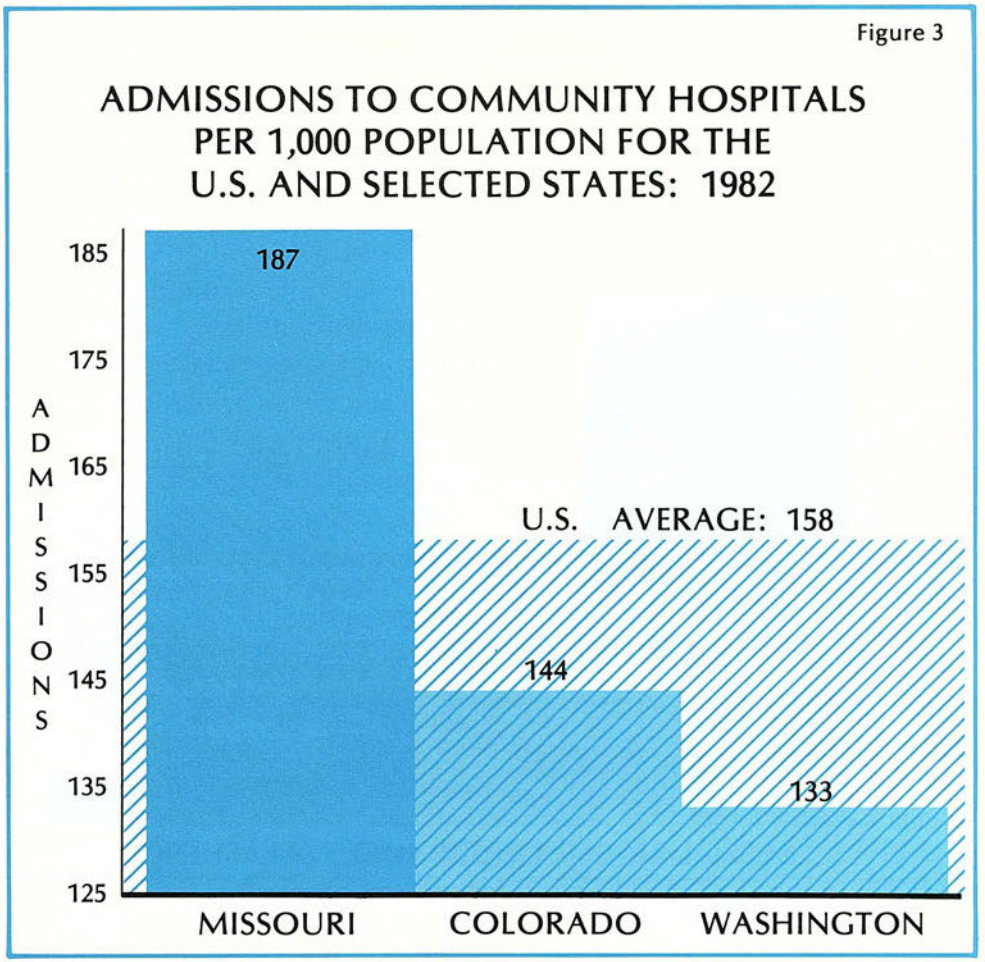
* Sources for all figures are provided in the back of this report.

Figure 2



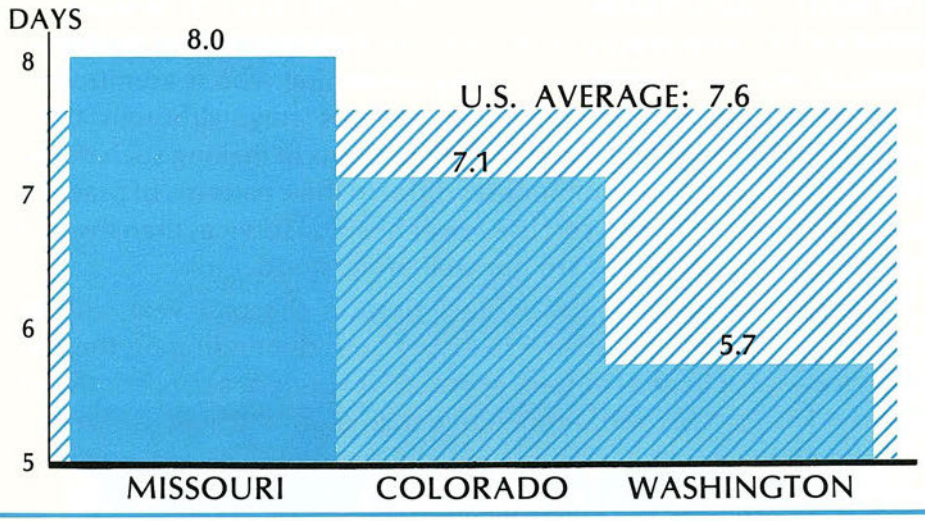
The number of hospital days used is a product of the number of hospital admissions and the length of stay. On both of these measures—admissions and length of stay—Missouri is higher than the U.S. as a whole, and also higher than Colorado and Washington, with their more efficient systems. The hospital admission rate is particularly high; Missouri ranked seventh of the 50 states in 1982 with 187 admissions per thousand, compared with a national average of 158 and rates for Washington and Colorado 133 and 144, respectively (Figure 3).

Figure 3



The average length of stay in community hospitals was more than two days, or 35 percent, longer in Missouri than in Washington in 1982 (Figure 4). Although Missouri is only 5 percent higher than the national average, the difference in potential dollar savings is large. If the length of stay in Missouri had been at the national average of 7.6 days, instead of 8.0 days,

Figure 4



more than $50 million in hospital expenditures would have been avoided. Furthermore, the length of stay in Missouri should be lower than the national average if a higher proportion of less severely ill patients are hospitalized, as the high admission rate suggests.

Comparative data on nursing home utilization is limited but also show that Missouri has a high user rate. Some 6.3 percent of the elderly in Missouri are in nursing homes, 15 percent above the nation as a whole.[7]

[7] Calculated from: Bureau of the Census, **Statistical Abstract of the United States,** Washington, D.C.: U.S. Department of Commerce, 1977 and 1982.

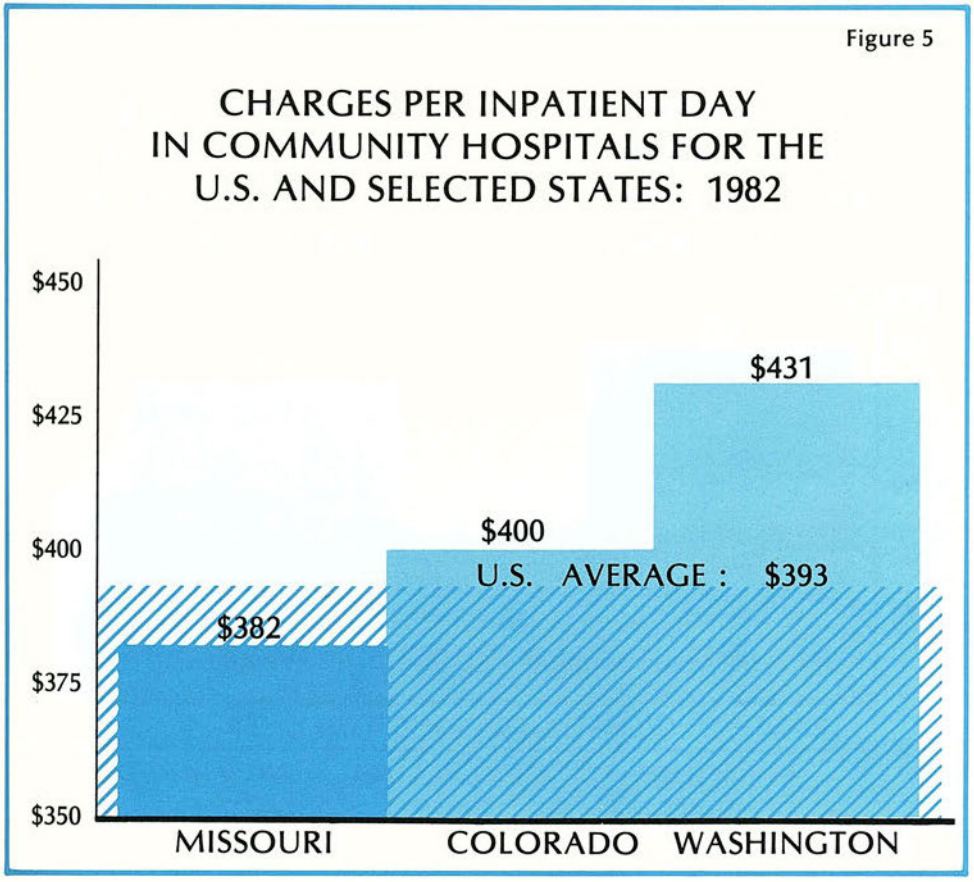
A number of explanatory factors can be suggested for the high rates at which Missourians use hospital and nursing home services, none of which constitute completely satisfactory explanations. The state's rural character increases travel distances and makes outpatient care more inconvenient. High bed supply, discussed below, encourages greater use. Also, the state does have a higher than average proportion of elderly in its population. The predominant reason, however, is that physicians in Missouri have a pattern of medical practice that results in their generating greater use of medical resources. Physicians largely determine who is admitted to the hospital and how long individual patients stay, although they are influenced by the preferences of their patients in making such decisions. Physicians in different communities differ in their patterns of practice; for example, patients in the West use fewer hospital services than those in the Midwest, for reasons that are not well understood.

Nationwide, hospital use is declining. In the past year, substantial reductions -- in the range of 5 to 10 percent, depending on the specific measure -- have been reported. Missouri's experience parallels that of the nation.[8] The Task Force has concluded that, given the high use rates in our state, the trend toward less inpatient and more outpatient care should be accelerated in ways that do not sacrifice quality or increase patient risk.

Health care prices in Missouri do not appear to be substantially higher than in other states. Only hospital prices were examined, because data on other providers are not readily available. Hospital charges per day in Missouri are slightly below the national average and are also below those in Colorado and Washington, the two states selected for purposes of making comparisons (Figure 5). Hospital costs per day, which influence how much hospitals charge, are also slightly lower, and these differences persist when adjustments are made for differences in hospital employees' wages in Missouri compared with the nation and with other states.

[8] Between 1982 and 1983, according to the American Hospital Association, hospital inpatient utilization dropped 4 percent in Missouri, compared to 2.7 percent nationwide. More recent data show further declines for the U.S. as a whole and for Missouri.

Figure 5

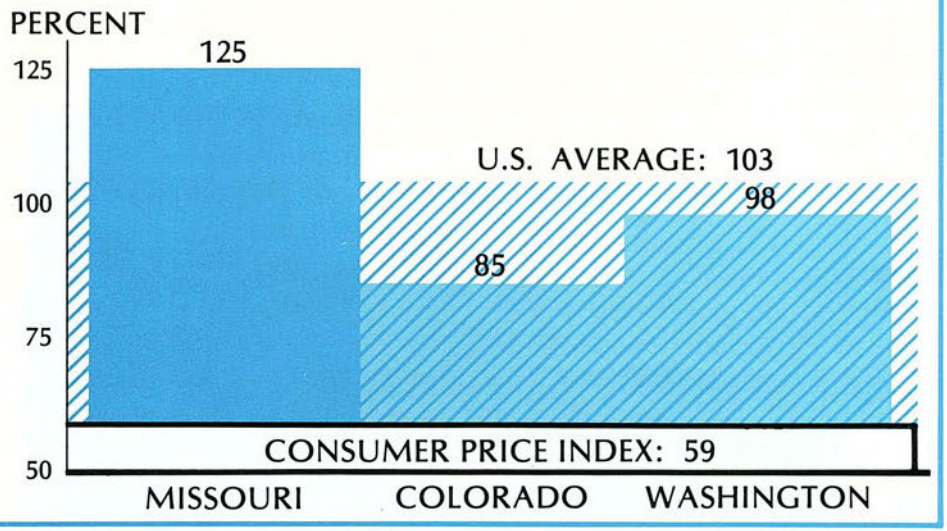


Charges per day are often used as an index of hospital prices. However, they are an imperfect measure because they do not reflect differences in how long patients stay in the hospital.

Between 1977 and 1982, the rate of increase in charges per day in Missouri was 22 percent higher than for the U.S. as a whole and more than twice the increase in the CPI (Figure 6). This demonstrates the need to be vigilant about prices as well as utilization.

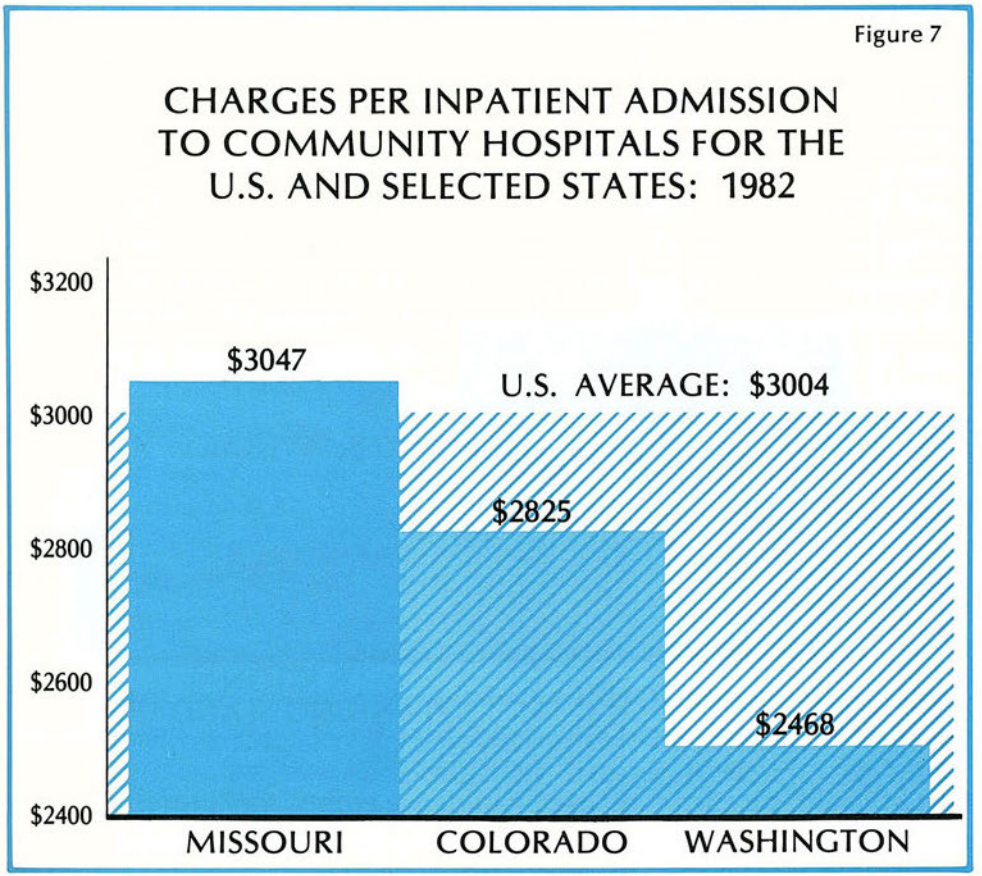
Figure 6

PERCENTAGE INCREASE IN CHARGES PER INPATIENT DAY IN COMMUNITY HOSPITALS AND THE CONSUMER PRICE INDEX FOR THE U.S. AND SELECTED STATES: 1982



In addition, one would expect charges per day to be lower where the length of stay is long because the costs of ancillary services, such as diagnostic tests, are spread over more days. As a result, payors increasingly are focusing on price per admission as an indicator of economic performance. The new Medicare hospital payment system, for example, established prices per admission. Measured by charges per admission, Missouri, because of its longer than average length of stay, is slightly above the national average (Figure 7).

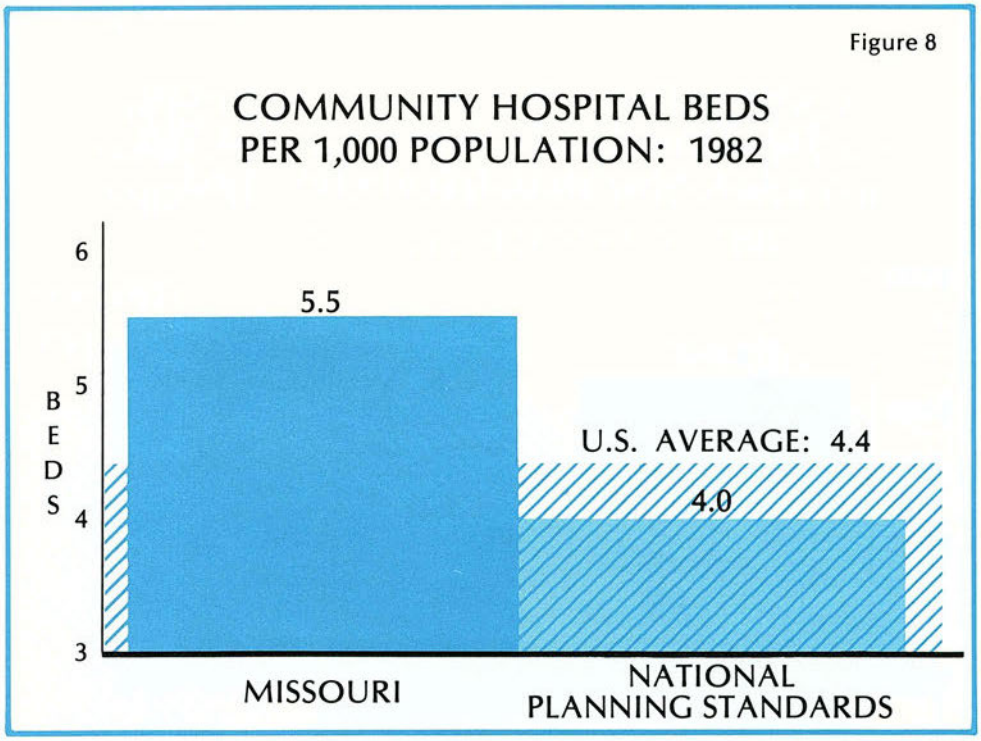
Figure 7



In summary, Missouri's health care cost problem appears to result more from high utilization than from high prices. (Focusing exclusively on utilization and ignoring prices would be a mistake because, as use rates decline, health care providers could raise their prices to compensate for lost revenues.)

One of the factors contributing to higher costs in Missouri is excess capacity. Excess capacity in hospitals and nursing homes can increase the

Figure 8



cost of health care services. Even if beds are empty, the interest expense and other fixed costs associated with those beds still have to be paid. In addition, excess capacity creates additional demand. Unused capacity can create pressures to fill beds with marginal admissions and to extend length of stay. It can also retard efforts to shift care to outpatient settings.

Missouri clearly has excess hospital and nursing home capacity. The state has 5.5 community hospital beds per 1,000 population, which is above the national average of 4.4 beds and well above the national planning guideline of 4.0 beds (Figure 8).[9] Many states have fewer beds than the planning guideline. Washington, for example, has fewer than 3.5 beds.

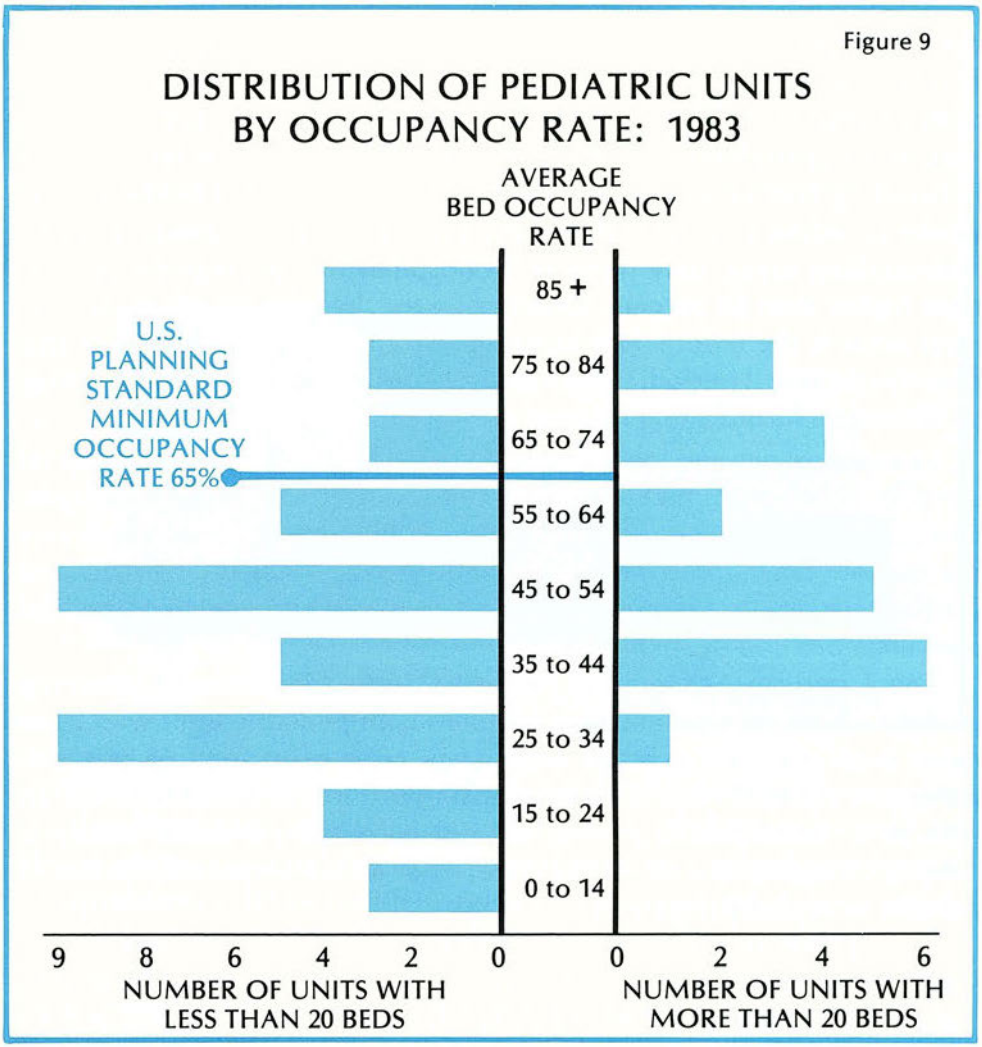
Because Missouri has so many hospital beds, occupancy rates are low, even with the high use rates. In metropolitan areas, only one in four non-federal general care hospitals in Missouri had an average occupancy of 80 percent more in 1983. One would expect lower occupancy in rural areas due to problems of seasonality; the difficulties of smaller hospitals in handling fluctuations in demand for services; and the likelihood that weekend admissions would be less common. Nonetheless, in non-metropolitan areas, only three in 10 hospitals had average occupancy rates higher than 65 percent. One reason for the high supply of beds in rural areas is the federal Hill-Burton program, which, for much of the post-World War II period, subsidized the construction of hospitals, using an allocation formula that favored rural areas.

Low occupancy and low volume also exist in many individual hospital services in Missouri, including pediatrics, obstetrics, and cardiac care. Low volumes and low occupancy can result in inefficiency that increases the cost of care. Furthermore, for some services, such as pediatrics and cardiac care, very low volumes are associated with higher rates of medical complications and death.

The American Academy of Pediatrics and national health planning guideline both recommend that hospitals with pediatric units with 20 or more beds maintain average occupancy rates of at least 65 percent. However, in 1983 14 out of 22, or almost two-thirds of Missouri hospitals with 20 or more pediatric beds, did not meet this minimum standard. Among all pediatric units in the state, 49 of 68 units operated below 65 percent occupancy (Figure 9).

[9] The national health planning guidelines were developed by the U.S. Department of Health and Human Services under the National Health Planning Act. They represented recommendations on the appropriate availability and volume levels for selected health care resources, such as hospital beds. While many observers feel that more stringent standards could be met while assuring access to care, the national guidelines are frequently cited as a starting point for formulating goals for state and local health care systems. The guidelines are presented and described in: **Code of Federal Regulations.** Title 42, Part 121, Washington, D.C.: U.S. Government Printing Office, 1983.

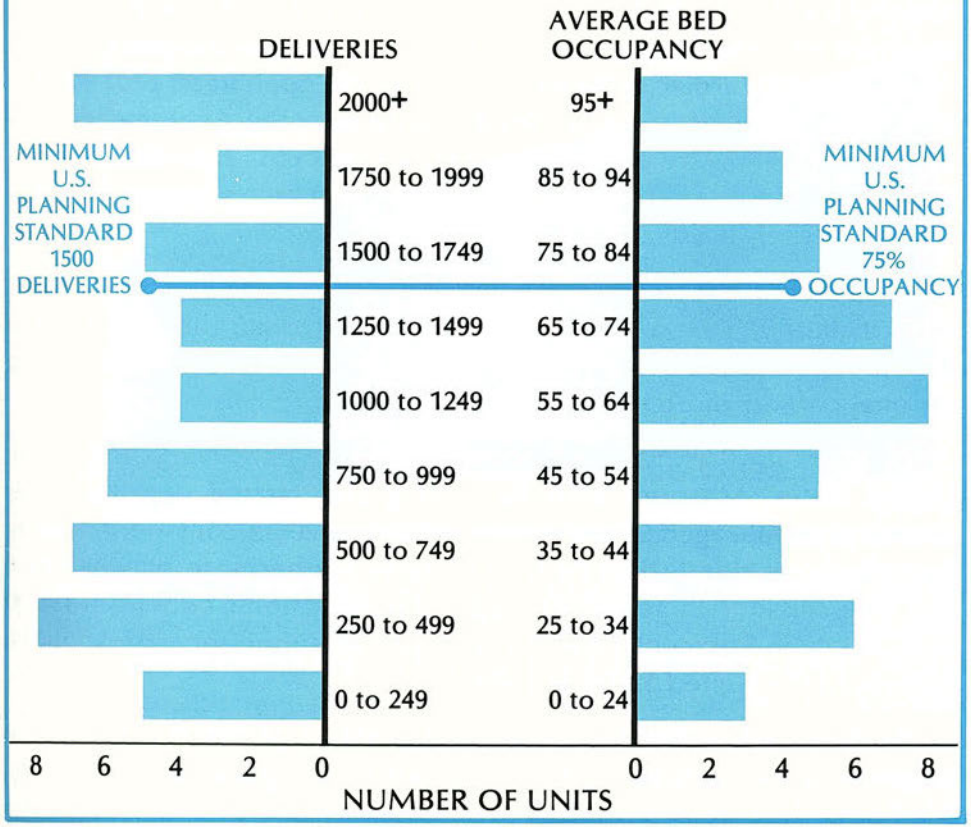
Figure 9



Obstetrical units are classified according to whether they are equipped to routinely handle complicated deliveries. The national planning guidelines recommend that units capable of handling such deliveries perform

Figure 10

DISTRIBUTION OF OBSTETRIC UNITS CAPABLE OF HANDLING COMPLICATED CASES BY NUMBER OF DELIVERIES AND OCCUPANCY RATE: 1982



at least 1,500 deliveries annually and maintain average occupancy rates of at least 75 percent. However, in 1983 seven of every ten such units in Missouri operated below these guidelines (Figure 10). Furthermore,

because projections indicate that birth rates will be stable or decline in the near future, and length of stay will probably continue to decline, an increasing number of units are likely to fall below these minimal volume levels.

Missouri also has adult cardiac units with low, volumes of patients. The national planning guidelines, which are based on a review of the medical literature on catheterization and mortality rates, call for minimum annual volumes of 300 cardiac catheterizations and 200 open heart procedures. One of every four hospitals in Missouri fail to meet these volume levels in 1983. Low volumes are a particularly serious concern for cardiac services because studies have shown that units operating below minimum levels achieve poorer health outcomes.

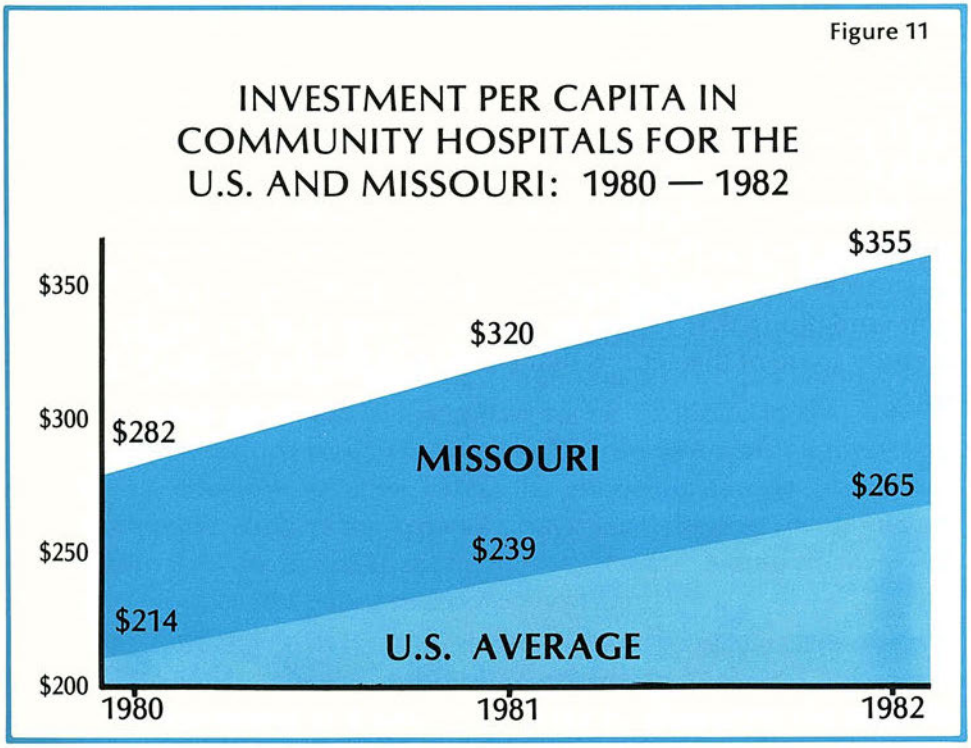
Although Missouri already has excess hospital capacity, capital investment in hospitals on a per capita basis has outpaced the U.S. average (Figure 11). Between 1980 and 1982, such investment in Missouri exceeded national rates by more than 30 percent annually.

Missouri also has high level of nursing home beds compared to the United States. Missouri, with 72 nursing and related care beds per thousand people aged 65 and older in 1980, had 20 percent more nursing home beds per elderly than the United States. Furthermore, between 1976 and 1980, Missouri increased its supply of nursing home beds from 33,700 to 46,700, or 38.6 percent. Over the same period, supply increased only 8.6 percent in the United States as a whole.[10]

As discussed earlier, the underlying problem of health care costs in Missouri is the lack of an effective market discipline. Until recently, Medicare, the biggest purchaser of hospital care, placed few limits on the amounts it paid or on utilization. Private insurers and self-insured

[10] Bureau of the Census, **Statistical Abstract of the United States,** Washington, D.C.: U.S. Department of Commerce, 1977 and 1982.

Figure 11



companies generally reimbursed based on provider-established charges or costs. They have also made little effort to restrain utilization. Also,competitive approaches to organizing and delivering health services, such as health maintenance organizations (HMOs) or preferred provider organizations (PPOs), have until recently been few in number.

However, change is beginning to occur, and this is encouraging. Provider attitudes are changing, and many providers are responding, often in innovative ways, to the challenges of recent pressures to manage health care costs. The business communities in Kansas City and St. Louis have organized coalitions to address health care cost management issues. Employers, unions, and insurance carriers are increasing their capacity to

review utilization and negotiate payment levels. Enrollment in HMOs is increasing. In 1983, 219,000 Missourians (4.4 percent of the population) were enrolled in HMOs, compared to 54,000 in 1976. However, enrollment is still below national levels of 6.5 percent and of more than 9 percent in both Colorado and Washington.[11]

Left unaddressed, the problems will remain severe. The pressures for change in the health care system in Missouri need to be intensified and channeled into the areas of highest potential payoff. The recommendations that follow in the next three chapters are intended to identify some of the actions that public and private groups can profitably take.

[11] Calculated from: InterStudy. **National HMO Census: June 30, 1983.** Excelsior, Minnesota: InterStudy, 1984.

Bureau of the Census, "Estimates of the Population States: July 1, 1981 to 1983 (Advance Data)," **Current Population Reports,** Series P-25, No. 944, Washington, D.C.: U.S. Department of Commerce, January 1984.

III. HEALTH CARE FINANCING REFORMS

BACKGROUND

An effective cost-management strategy must incorporate incentives for consumers to make prudent choices. Unfortunately, many people with private health insurance coverage have plans that pay in full for certain services, particularly hospital services, and that also fail to incorporate incentives to use cost-effective providers.

In 1982, 83 percent of member companies in the St. Louis Area Business Health Coalition offered first-dollar coverage, i.e., coverage with no patient cost sharing (deductibles, copayments, or coinsurance) for at least some services.[12] Such coverage creates two problems. First, consumers have no financial incentive to be cautious in the use of services or to question physicians who might order them, nor is there any incentive to consider relative prices in choosing among providers. Second, because such plans typically have cost sharing on physician services but not on hospital services, they create biases in favor of inpatient care over less expensive outpatient care.

The rise in health costs has stimulated some large purchasers-of-care to act. In late 1981, concern about rapid growth in Medicaid expenses, which were increasing at a rate of 32 percent, prompted the state to institute a series of changes. These changes have shifted the focus of care from inpatient facilities, such as hospitals and nursing homes, to less costly settings, such as physician offices and other ambulatory care settings. The state also took steps to prevent the delivery of unneeded services and launched an initiative to contract with prepaid health care systems in Kansas City. This restructuring has allowed the state to hold the rate of increase in Medicaid expenses to 5.7 percent in FY 1982 and 7.2 percent in FY 1983.

Private purchasers have also begun to take significant actions.[13] In

[12] St. Louis Area Business Health Coalition, op. cit.

[13] By private purchasers, we mean employers, union trust funds, carriers, or other organizations that must purchase, or bear the cost of, health care benefits.

addition to restructuring benefits to encourage employees to be more cost conscious when they seek health care, purchasers can (1) offer consumers multiple choices among competing health plans and (2) redesign their plans to favor efficient providers.

Employers are increasingly offering alternatives to conventional insurance plans. Health maintenance organizations (HMOs) are among the oldest and most successful of such alternatives. Essentially, HMOs deliver comprehensive medical services to voluntarily enrolled subscribers in exchange for a prepaid premium. The HMO employs or contracts with physicians whose remuneration depends on their ability to live within the HMO's budget. It also makes arrangements with hospitals that are efficient and have reasonable prices. Thus, in contrast to the fee-for-service system, which rewards providers for increasing the amount of care delivered, HMOs incorporate incentives to control costs. The savings that HMOs realize have been well documented over the past decade as has the quality of care that most provide. However, even in areas where HMOs have achieved particularly high enrollment, they have not always created the market discipline necessary to generate savings in the fee-for-service system.

In addition, some believe that HMOs tend to "price-follow" by setting their premiums just below those of the typical indemnity plan in the community. However, a few employers have successfully negotiated premiums that are lower than those the HMOs would otherwise charge.

Selective contracting between purchasers and a limited number of providers is a more recent approach to health care cost management. Selective contracting can take many forms, the most prominent of which entails entering into agreements with preferred provider organizations (PPOs). PPOs entail arrangements with a panel of providers (doctors, hospitals, dentists, etc.), who are selected to participate based on their having favorable prices and utilization patterns. The prices are usually agreed to in advance and may reflect discounts below usual charges. The

PPOs also typically have mechanisms to review carefully the services that they provide. Indeed, many believe that effective utilization review is the key to achieving savings. Unlike the provisions in an HMO, PPO enrollees can decide, service-by-service, whether to use a participating provider. However, the cost sharing is reduced if they do. The resulting reduction in out-of-pocket expenses is an inducement for patients to use participating providers.

Competitive strategies should not only incorporate incentives for consumers to be economical in their use of health care but should also create pressures for providers to change their behavior. The Task Force endorses recent trends away from cost reimbursement to prepayment and prospective payment systems that complement the marketplace approach. Prospectively set prices, particularly when combined with comparative data that is widely disseminated and consumer incentives to select efficient providers, can help in controlling health care costs. (The issue of data availability is discussed in Chapter V.)

Moreover, the Task Force recognizes that efforts to promote competition and prudent purchasing of health care deal with only part of the problem of rising costs. These measures do not necessarily curtail the proliferation of expensive technologies, such as magnetic resonance imaging (MRI). Indeed, competition may actually increase pressures for providers to duplicate services or technologies. Some PPOs, for example, believe that they can compete better by offering comprehensive services regardless of whether doing so results in duplication. (Approaches to reducing excess capacity are discussed in Chapter IV.)

The state also has a responsibility to protect vulnerable members of our society whose welfare cannot be assured under a competitive approach. When hospital revenues are squeezed through efforts to reduce payments and utilization, as is increasingly the case, hospitals have less flexibility to provide uncompensated care to indigent patients. It is possible, however, principally through state and federal efforts, to assure

coverage for citizens who cannot otherwise obtain insurance, either because their incomes are too low or because of their poor health status.

Another factor that contributes to increases in health care costs is the rise in premiums for medical malpractice insurance. These higher premiums are, of necessity, passed along to the consumer in higher prices for medical services.

PRINCIPLES

- Health benefit plans should provide financial incentives for consumers and providers to be efficient in the use of health care services.
- Marketplace approaches hold the best promise in Missouri to constrain the rise in health care costs. However, legislation may be necessary to ensure that (1) competition occurs among health care plans and among providers and (2) purchasers and consumers have adequate information on which to base decisions.
- Missouri law should enable the private sector to form competing alternative delivery systems.
- There is a need to assure that increased competition and cost containment pressures do not exacerbate either the problems of access to care among indigent populations or the inequities among providers resulting from differences in the amount of charity care that they render. Employers and insurers can reduce this problem by assuring access to coverage for the employed population. Also, the state should exercise its responsibilities for its beneficiaries through coordinated programs that are consistent with the promotion of competition on the basis of price and utilization patterns.
- Malpractice suits have been a cause of high health care costs and should be addressed.

RECOMMENDATIONS

Recommendation 1: Health insurance plans should avoid first dollar coverage but should also incorporate adequate protections against financially catastrophic illness. They should also incorporate other provisions to limit unnecessary medical care, such as promoting second opinions for surgery, requiring prior certification for non-emergency hospital admissions, promoting alternatives to inpatients treatment, and retaining cost sharing for persons covered under more than one policy.

For reasons described in the Background section, insurance plan design features are a critical part of any cost-management strategy. Although purchaser and carrier must make their own decisions regarding how they wishes to structure its benefit plans, the key features that should be considered include the following:

Adoption of Cost Sharing. Increasingly, employers are moving away from first-dollar coverage and are, instead, adopting health benefit plans that impose cost sharing on all, or almost all, service, including both inpatient and outpatient care. To protect patients from financially catastrophic illnesses, comprehensive plans usually limit total cost sharing (e.g., to $1,000 in out-of-pocket expenses in a year) and reimburse in full for charges incurred above the limit.

Many Missouri employers are, in fact, redesigning their plans to incorporate cost sharing. A survey by the St. Louis Area Business Health Coalition found that 49 percent of member companies now offer at least one plan with cost sharing on most or all services, and 34 percent have increased deductible levels.[14] The Coalition is also disseminating information on benefit redesign and other cost containment approaches for employers in eastern Missouri. In addition, the Kansas City Health Care Coalition has developed a model benefit package to assist member firms

[14] St. Louis Area Business Health Coalition, op. cit.

to make similar changes. Finally, in January 1984, the state changed its employee benefits program from a first-dollar plan to one with 20 percent cost sharing, mandatory second opinions for surgery, payment for outpatient surgery, and denial of weekend admissions for non-emergencies.

Second Opinions for Surgery. When non-emergency surgery has been recommended, some benefit plans require that a second physician be consulted to render an opinion. This provision can be optional with the patient, or it can be mandatory. Mandatory programs usually list the procedures for which second opinions are required. Patients who fail to obtain a second opinion are typically penalized through higher cost sharing. Because mandatory programs entail financial incentives, the Task Force believes them to be more effective than voluntary ones.

Prior Certification for Non-emergency Hospital Admissions. One of the most effective containment measures is to require that patients, or their physicians, obtain authorization through the health benefits plan prior to hospital admission, except in an emergency situation. Reimbursement penalties, such as an extra copayment or additional coinsurance, is typically imposed if the requisite authorization is not obtained. Prior certification is part of the utilization review process, which is discussed further in Chapter V.

Alternatives to Inpatient Treatment. A number of approaches can be taken to encourage the use of outpatient settings when appropriate for the patient, including:

- Covering diagnostic testing prior to a hospital admission to avoid the expense of an extra day of inpatient care.
- Encouraging the performance of surgery on an ambulatory basis.
- Having a program of prior authorization for non-emergency hospital admissions.

- Undertaking discharge planning for hospitalized patients, combined with promoting the use of home health services.

Reducing Duplicate Coverage. With the increase in two-earner families, duplicate coverage has become more widespread. The insurance industry has adopted practices that are known as coordination of benefits. Their purpose is to ensure that, where someone has coverage under more than one plan, the enrollee does not receive payment for more than 100 percent of the medical bill. Although coordination of benefits is important, the Task Force recommends that employers also seek ways to discourage employees from having duplicate coverage altogether. Furthermore, where duplicate coverage does exist, employers should find ways to assure that the two plans combined do not pay 100 percent of the bill, so that cost sharing is retained. Potential measures include:

- Have employees share in their health benefit premiums, thereby making duplicate coverage less desirable.
- Assuring that if one spouse loses a job, the other can be immediately insured, even if he or she did not previously elect coverage, thereby reducing the incentives to accept duplicate coverage.
- Having the two plans combined pay no more than the most generous plan would pay if it were the only coverage in force.

Recommendation 2: Both the state and the private sector should encourage the continued development of competing alternative delivery systems, such as HMOs and selective contracting arrangements.

A major strategy for introducing competition into health care is to promote alternative delivery systems that compete among each other and with the traditional fee-for-service system. The Task Force believes that the widespread availability of organized alternative delivery systems

can help create a market discipline. Although these systems can take many forms, the most common are HMOs and selective contracting arrangements, including PPOs.

HMOs. Although Missouri has experienced rapid HMO growth in recent years, there are only 7 HMOs operating in the state today, and they have low market penetration. It is notable, however, that 4 of the 7 were established since 1981, and as of September 1984 the 7 plans had 218,790 enrollees, more than a doubling in less than three years (see Table 1). Nevertheless, HMO enrollment still represents only 4.4 percent of the population, compared to some 6.5 percent nationally.

A number of steps can be taken to promote HMO enrollment. First, the Missouri state employee benefits program can use its clout and market share. For example, the State agencies, including the university system, could foster the development of an HMO in central Missouri, where one does not currently exist.

In addition, licensure requirements for HMOs should be revised. At present, nonprofit HMOs are licensed under the Health Services Corporation Code, which was designed to regulate health plans, such as Blue Cross and Blue Shield; for-profit HMOs are licensed under laws that are intended to regulate commercial insurance companies. The effect is, simultaneously, to place demands on HMOs that are excessive in some respects and to provide insufficient consumer protection in other respects. Thus, state licensure laws should be altered to reflect the specific characteristics of HMOs.

Finally, one reason for low enrollment is that many persons are unaware of HMOs or do not understand their characteristics. Furthermore, both attitudes that employers convey and the ability of HMO representatives to communicate with employees have a significant impact on enrollment. The Task Force believes that the awareness of HMOs among the population as a whole should be enhanced and that employers should be encouraged to facilitate HMO access to employees.

Table 1
HMOs In Missouri
Enrollments by Plan

Plan	Age	Enrollment By Plan Jan. 1, 1982	Sept. 1984
St. Louis			
Labor Health Institute	39	24,107	20,683
Healthcare Network (includes Medical Care Group)	15	24,495	38,191
Group Health Plan	2	--	27,650
Individual Practice Program	3	--	10,000
Maxicare	1	--	6,000
Kansas City			
Prime Health	7	42,019	52,421
Kansas City Health Care	0	--	8,038
Total Health Care	2	3,900	54,863
Health Plan of Mid-America	0	--	944
TOTAL		94,521	218,790

Sources: Council of the Missouri State Medical Association. **Study of Missouri HMOs, PPOs, Hospital Satellite Clinics, Freestanding Emergency Care Centers** March 1984, and telephone calls to individual HMOs.

Selective Contracting/PPOs. The Task Force believes that selective contracting arrangements between private plans and individual providers should be encouraged. The most common form of selective contracting is the PPO, as described in the Background section, and entails the

purchaser or carrier introducing plan-design incentives, typically lower patient cost sharing, as an incentive to use participating providers.

Nationally, several hundred PPOs are in various stages of development, but only a few dozen have a significant number of enrollees. Arriving at an exact count of PPOs in Missouri is difficult. To date, seven are known to be in operation with estimated enrollments that approach 100,000. Five of the PPOs are sponsored by providers, either networks of hospitals and physicians or individual physician groups. Two are sponsored by the Blue Cross and Blue Shield plans in Kansas City and St. Louis, respectively. In addition to the seven that are currently operating, at least four are in a developmental stage.

In an effort to promote PPO development, several states -- notably California, Florida, Minnesota, Virginia, and Wisconsin -- have revised their insurance codes to authorize private insurance carriers to selectively contract with providers. However, changes in the law have not been necessary in most states in order for carriers to engage in selective contracting, and the Task Force believes that Missouri falls in this category, notwithstanding some ambiguity in the insurance codes that may justify enacting a clarifying amendment.

Missouri insurance statutes also appear to permit certain selective contracting variations. Under one variation, the purchaser contracts with a panel of participating providers and will not reimburse for services rendered by non-participating providers, except in emergency situations. This model resembles an HMO in that it offers the advantages of a controlled health care system. In theory, therefore, the approach has the potential of achieving greater savings than PPOs.

Savings from PPOs can result from reliance on a combination of efficient providers, prospectively negotiated prices, and utilization controls. Purchasers should be aware, however, that savings from discounts can be more than offset by other factors. First, reduced patient cost sharing under the PPO benefits will increase benefit payments. Second,

the reduction in patients' out-of-pocket expenses could generate increased utilization. Finally, expenses could increase if the plan has the effect of channeling patients to less efficient or more costly participating providers. Thus, purchasers may incur higher expenditures under a PPO, unless effective utilization controls are in place and providers have been selected carefully. For these reasons, it is essential that data be available to assist purchasers in selecting providers and monitoring PPO performance (See Chapter V).

Recommendation 3: All parties need to be concerned that cost containment efforts do not reduce access for indigent populations. However, the responsibility of financing care to such populations rests primarily with federal, state, and local governments, with philanthropy playing a supportive role.

Efforts to promote price competition in the health care marketplace can adversely affect indigent populations who are not covered by either public programs, such as Medicare and Medicaid, or private insurance. Although little is known about the size of the uninsured poor population in Missouri, national data indicate that approximately 10 percent of the United States population is without any form of public or private coverage. Furthermore, this population may be increasing because of federal cutbacks in public assistance programs. The uncovered population also grows during periods of high unemployment.

As private purchasers begin to promote price competition among providers and otherwise restrain the growth in dollars flowing to health care, hospitals will have less flexibility to provide uncompensated care. Proprietary and non-profit private hospitals, in particular, may seek to shift charity care to public hospitals, which may not be in a position to absorb additional burdens.

The Task Force believes that payment of health care for the poor is fundamentally a public responsibility, with philanthropy playing a supportive role in filling critical gaps. The current state budget constraints are

recognized. However, as the economic climate improves, it is hoped that additional monies can be allocated to assisting uncovered populations.

Recommendation 4: Missouri law affecting medical malpractice should be amended to:

- **Grant the defendant or the plaintiff the right to require structured payment of awards, that is, payment in installments over several years rather than as single lump sums.**
- **Place limits on the portion of awards attributable to non-economic loss.**
- **Prevent double recoveries by plaintiffs through multiple awards from sources such as health insurance, worker's compensation, and malpractice judgments.**
- **Permit the courts to apportion recovery among multiple defendants, based upon comparative fault.**
- **By means of a graduated scale, limit the size of contingent attorneys' fees as a proportion of plaintiffs' awards.**
- **Authorize summary judgments in cases where there are no factual disagreements.**

In addition, the state should investigate the possibility of instituting a voluntary binding arbitration system.

After several years of relative stability in losses from claims for medical malpractice, the provider and insurance communities in Missouri are experiencing the onset of another stressful period. That characterization emerges from analyses of malpractice claims published since 1981 by the Statistical Section of the Missouri Division of Insurance. Four such reports have been issued, covering 1975-80, 1979-81, 1982, and 1983.

During most of the late 1970s, following several years of large premium increases, the malpractice insurance picture was not a particularly dim one. The rate of malpractice claims in Missouri was only

one-seventh that of the nation as a whole, and the average payment per malpractice claim was $15,587, 25 percent below the national average of $21,257.

For the 1979-81 period, however, the data reveal an upsurge in the payment of claims. In 1979, the ratio of losses incurred to premiums earned was 64 percent, indicating that the malpractice carriers were generating substantial surpluses. However, by 1981 payments for claims were exceeding the amount collected for premiums by 12 percent.

Between 1981 and 1982 claims payments rose dramatically, with payments increasing 60 percent on behalf of physicians and more than tripling on behalf of hospitals. The most recent figures, for 1983, while reporting a decline in claims frequency, show a further increase in settlement amounts with the average settlement rising to $53,583 from $39,887 for the previous year. Next year's figures are already destined to show a significant jump, reflecting a $27.5 million jury verdict in April 1984 against a hospital.

The malpractice experience in Missouri since 1981 has been reflected in insurance premiums. Indeed, one of the largest insurers in the state, the Missouri Professional Liability Insurance Association (which insures hospitals only) will increase its premiums an average of 80 percent in January 1985. As of September 1984 the premiums charged by the Medical Protective Company, one of the state's largest physician insurers, rose as much as 80 percent in the high risk surgical categories. Finally, Medical Defense Associates, a mutual association that insures only Missouri doctors, announced a 20 percent increase in January 1982 and a 49 percent increase in December 1983. A further increase may well occur before the end of 1984. The company's rates had remained level between 1979 and 1981 and had actually dropped in some risk categories between 1981 and 1982.

This escalation in malpractice premiums is reflected in the prices that providers must charge. Furthermore, in excess of 50 percent of the

premium dollar is used for lawyers' fees and other costs of administration rather than payments to injured plaintiffs.

Increases in premiums and in the number of lawsuits also contribute to the rise in health care costs by fostering the practice of "defensive medicine." Such practice entails the ordering of additional tests and services, not because of strict medical necessity but rather to document prudent physician and/or hospital behavior in the event a suit is filed.

The malpractice problem has no easy solution. The Task Force believes that its proposals will have a salutory effect without endangering the right of patients to recover through the court system where just cause exists. Their aim is to engender greater predictability and reasonableness, as well as fairer apportionment, of recovery amounts.

By the same token, these proposals represent only a partial solution. The health care delivery system is not perfect, and patients do on occasion suffer injury while being treated. Some of those injuries result from negligence. Thus, while favoring changes in Missouri's legal system to rationalize any resulting compensation, the Task Force also calls for continued efforts to prevent those injuries in the first place. Strengthened peer review, tougher discipline procedures to deal with medical incompetence, continuing education for health care professionals, and a renewed emphasis on better physician-patient communication should all be pursued in the interests of malpractice prevention.

Recommendation 5: In the current environment of rapidly rising health care cost, the state should avoid mandating new benefit expansions on the private sector.

Various proposals have been advanced for the state to enact legislation to mandate that health insurance plans cover certain benefits or pay for services rendered by certain practitioners. Benefits that are currently mandated include coverage of (1) newborns from birth, (2) handicapped children with no age limit, and (3) limited mandated benefits for

treatment of alcoholism. These benefits protect against the high cost of catastrophic illnesses that, if not covered, could impoverish stricken families and contribute to the problems of hospitals' bad debts.

The Task Force believes that, in a competitive marketplace, the structure of a benefit plan should result from a bargaining process between employers and employees, with particular attention given to costs. Furthermore, until progress is made to constrain the rise in health care costs, mandating additional benefits, however worthy, could be counterproductive because it could cause marginal companies to drop coverage altogether. Finally, mandating additional benefits would not affect self-insured groups, since by federal law these groups are exempt from state health insurance regulations. Thus, such mandates reach a limited portion of the population and create biases towards self-insurance. However, the Task Force does recognize that there may be exceptional circumstances that may justify further mandates, as exemplified by the current provisions relating to newborns and handicapped children.

IV. CONTROLLING CAPACITY IN THE HEALTH CARE SYSTEM

BACKGROUND

As part of any effort to contain health care costs, excess hospital and nursing home capacity must be controlled. Excess capacity increases costs in several ways.

- It encourages additional use of hospitals and nursing homes by stimulating longer stays and admissions for marginal conditions.
- The presence of substantial excess capacity can militate against outpatient care or care by new, lower cost providers, because existing facilities often generate economic and political pressures to "protect" the community's investment in existing facilities.
- Even when hospital use declines, the fixed costs of the facility --depreciation, interest, maintenance, and so forth -- remain. The community can face large ongoing costs for an empty or underutilized plant.

Missouri has more hospital and nursing home capacity than is needed. As was discussed in Chapter II, the state has 5.5 community hospital beds per thousand people, substantially higher than the United States average and eighth highest among the states. Although occupancy rates approximate national averages (which, in turn, are low), they do so only because Missourians use inpatient hospital care at a high rate, reflecting in large measure the practice patterns of physicians. Furthermore, despite low occupancy, hospitals have expanded their inpatient capacity over the past decade, thereby exacerbating the situation (See Table 2).* The problems will become even more severe in face of the declines in hospital utilization that are now occurring.

The number of beds that are in excess can be estimated in several ways. If Missouri were at the national average of 4.4 beds per thousand people,

* The data for 1983 in Table 2 differ slightly from the data in Chapter II, which are for 1982, the latest year for which such data are available on all states.

Table 2
Missouri Community Hospital Capacity
1973 and 1983

	1973	1983
Beds	23,932	27,418
Beds Per Thousand People	5.0	5.5
Occupancy Rate	78.2%	71.1%
Occupancy Rate in Metropolitan Areas	80.8%	74.6%

Sources: American Hospital Association. **Hospital Statistics** 1974 ed. Table 6 Chicago: American Hospital Association, 1974. 1983 data prepared by the Missouri Hospital Association based on the American Hospital Association's **Annual Survey of Hospitals** for 1983.

it would have 21,800 beds, 5,600 fewer than at present. This 20 percent decline would be equivalent to closing sixteen 350-bed hospitals.

If hospital use were lower, occupancy rates in Missouri would also be lower, and there would be even greater excess. For example, if utilization were reduced from its current level of 1,433 to 1,200 days per thousand population, approximately the national average, and occupancy was at 85 percent in metropolitan areas and 70 percent in non-metropolitan areas, only 20,000 hospital beds would be needed. This represents some 7,400 or 27 percent, fewer beds. At 1,000 days per thousand, a level achieved in states such as Oregon, Washington, and California, the number of beds needed would be 16,700. This represents a decrease of more than 10,000 beds, 39 percent of current capacity.

Chapter II indicates that there may also be excess capacity in specific services, such as pediatrics, obstetrics, and cardiac surgery. There also is evidence that hospitals are seeking to introduce new technologies, such as magnetic resonance imaging (MRI) screening before their appropriate uses are fully known and at a time when the technology is evolving rapidly. As a result, Missourians may face paying for replacement equipment sooner than if its hospitals delayed their purchases.

As with hospitals, Missouri has a substantial supply of nursing home beds. In 1980, Missouri ranked 16th highest among the states and was 20 percent above the national average for number of beds in nursing and related care facilities per thousand population aged 65 and older.[15] Like hospitals the growth in nursing home beds continues to be rapid, with over 10,000 beds being added in the last six years, as shown in Table 3. Data in Table 3 are more recent and not directly comparable to the numbers in Chapter II for state comparisons.

Community leaders often view hospital and nursing home construction as contributing to the local economy. What must be recognized, however, is that these efforts are funded through higher taxes (or reductions in other government services) and increases in health insurance costs that crowd out improvements in wages and salaries. The Task Force believes that the cost of unneeded capacity has become unacceptable and that development should be directed to activities with higher pay-offs for our citizens.

Hospital and nursing home growth has been facilitated by the expansion of private and public health insurance and the practice of these insurers of reimbursing on the basis of actual costs incurred or provider-established charges. Hospitals and nursing homes have been able to invest in new plant and equipment knowing that their costs would be covered, and thus some marginal projects have been pursued.

[15] Bureau of the Census. **Statistical Abstract.** op. cit.

Table 3
Missouri Skilled Nursing and Intermediate Care Facility Capacity 1978 and 1984

	1978	1984	Growth 1978-1984
Beds	35,459	45,725	29.0%
Beds Per Thousand Population 65 and Over	56.4	68.1	20.7%

Source: Calculated from unpublished data from Missouri Department of Social Services

Now that the methods of paying for health services are beginning to exert restraints, the incentive for building marginally needed health facilities is reduced. The Task Force does, however, see drawbacks to relying exclusively on market forces in the short term:

- An effective, competitive market for health services is not yet fully developed in Missouri and there is a need to control expansion until market forces are better established.
- Reductions in unneeded capacity can be slow. In some communities, rather than reducing capacity, hospitals' initial reaction to declining use has been to develop new or expanded inpatient services in areas such as drug dependency and psychiatry rather than to invest in facilities for outpatient care.
- Adjustments can also be painful. The market creates pressures for reducing capacity by weakening an institution's ability to provide high quality care and can dissipate the resources

needed to redirect its program or merge with another institution. Experience in other states suggests that the institutions most vulnerable to this financial pressure are commonly those serving the Medicaid clients and the uninsured. Private and public actions can help ease these adjustment problems.

The Task Force believes two types of activities are required to control capacity besides relying on the market. The first is to encourage health facilities to reduce capacity earlier than they might otherwise do. The second is to strengthen government programs to restrain future facility growth, including the state's certificate of need program and the 1983 moratorium on the construction of additional hospital and nursing home beds. These measures are viewed as transitional until marketplace forces are operating effectively.

PRINCIPLES

- There is excess institutional health care capacity in Missouri that should be reduced.
- Over the long term, reliance should be placed on market forces to create downward pressure on capacity. However, in the short run, there is a need for actions to:
  - -- Keep the problems of excess capacity from becoming worse;
  - -- Ease and speed adjustment to minimize the impact on quality of care; and
  - -- Encourage adjustments to occur in a manner that preserves access to care for the poor and the uninsured and also protects necessary medical education programs.
- No new capacity should be built until market forces develop, except for perhaps a few selected services or in specific, rapidly growing areas.

- Voluntary actions by institutions to reduce capacity or close should be encouraged. Providers not subject to current controls on investment, such as the hospitals that are part of the state university system, should be encouraged to endorse the recommendations in this report and reflect them when they plan capital projects.

Recommendation 6: The state should ensure that information on overall community hospital use and individual hospital volume is analyzed and disseminated.

The Task Force believes that there is excess hospital capacity in Missouri and that this excess will grow substantially as the state's high hospital use rates are lowered. As a result, downsizing the hospital system is critical. The initiative for downsizing will come principally from the hospitals themselves; however, this will likely occur only when hospital trustees, administrators, and medical staff come to accept that utilization will continue to decrease, that fiscal constraints from payors will intensify, and that these trends cannot be accommodated simply by their particular hospital increasing its market share.

Information can play an important role in changing attitudes and stimulating hospital closures, bed reductions, mergers, and consolidation of services. Data that are currently available include:

- Hospital use and occupancy rates for the state as a whole and for each metropolitan area and region within the state.
- Individual hospital's patient days, occupancy rates, and utilization levels of specific services, such as pediatrics and cardiology.

Analyses of these data would complement the data disclosure and dissemination efforts described in Chapter V. They can be conducted by either a private organization or the state. Regardless, the state has a

responsibility to ensure that the necessary data are collected, analyzed, and disseminated.

Recommendation 7: Hospital trustees should become more involved in formulating appropriate responses to declining hospital use and in identifying opportunities for merger or consolidation and changes in their respective hospital's role in the community. To assist trustees in playing this role, the state and private groups should conduct information programs for trustees on the changing hospital market.

Trustees play a unique role in not-for-profit health institutions. Ultimately responsible for their governance, trustees have become increasingly concerned that their hospitals not generate unnecessarily high costs. Furthermore, as representatives for their communities, they often take a broader view of the institution's role and mission than does the administrator or medical staff. As a result, they can be critical catalysts in encouraging early, appropriate responses by hospitals to changing market conditions.

The Task Force believes that trustees must be concerned about excess capacity and the increases in that excess that will occur as utilization is reduced. They should inquire how their hospitals will respond and should be skeptical of internal plans that have increasing market share as their sole objective. They should also consider opportunities for merger and for creating new multi-hospital systems in the state. Finally, they should find ways of working with the various health care coalitions in the state that have cost containment as an objective.

Because the hospital environment is changing so quickly and is creating new demands on trustees, the state and the business community should undertake programs to assist trustees. They can help inform trustees of changes in reimbursement, utilization control, and payors contracting with hospitals as well as of the likely impact of these changes on the hospital. Such programs could be sponsored individually or jointly

by the state or the health coalitions in St. Louis, Kansas City, and elsewhere.

The Task Force also believes that trustees need to organize to facilitate cooperative efforts among hospitals. Thus, it recommends that trustees consider forming metropolitan councils. Such associations exist in such diverse communities as Minneapolis; St. Paul; Rochester, New York; and Rockford, Illinois. Also, statewide associations have been formed in Maryland and New York. Metropolitan trustee councils also should establish a statewide network that can include trustees from rural communities. These groups could serve as forums for further trustee education and discussion and as a place where merger and consolidation discussions among institutions might be initiated.

Recommendation 8: The moratorium on hospital and nursing home development should both be continued and expanded to include specific services.

Missouri has enacted a limited moratorium on the development of new hospitals and nursing homes and on the expansion of current bed supply. The hospital moratorium prohibits hospitals in metropolitan areas from expanding their net capacity after October 28, 1983, until January 1, 1985. In other areas of the state, existing facilities may expand, but new ones may not be created. The nursing home moratorium prevents the addition of nursing home beds until after July 1986, and no new nursing homes may be constructed before July 1987. Some projects are exempt from the moratorium, such as intermediate care facilities for the mentally retarded and residential care facilities.

The moratorium has succeeded in slowing the growth of hospital and nursing home beds and should be extended for at least three more years. In addition, the moratorium should be expanded in the following ways:

- Hospital bed expansion should be prohibited in non-metropolitan counties with bed to population ratios greater than 4.0 beds per 1,000.

- The following services should be included within the moratorium:
  - -- development of new cardiac surgery or cardiac catheterization services;
  - -- development of new obstetrical and pediatrics services; and
  - -- development of new psychiatric or drug dependency services, except in communities in which inpatient services are not available within a one-hour travel time.

Finally, the Task Force recommends that, prior to the moratorium ending, the state consider establishing an annual ceiling on the amount of hospital and nursing home projects that can be approved under the certificate-of-need program. If market forces are not yet fully established, such a ceiling would help discipline certificate-of-need decisions.

Recommendation 9: The legislature should amend the certificate-of-need statute to expand participation by purchasers and consumers and to tighten the standards for project approval.

Certificate-of-need programs are difficult to administer stringently. The interest of those applying for approval to initiate or expand a service are clear and immediate to them; in contrast, the interests of the community in restraining development of marginal new services are diffused. Under these circumstances it is easier to mobilize forces to support additional investment in capacity than to oppose it; however, until market forces are more fully established, it is important to maintain a certificate-of-need in Missouri and to run it effectively.

There are two common approaches that states have adopted to review decisions of hospitals and nursing homes to expand or renovate: certificate-of-need and the federal 1122 program. Missouri was among the last states to enact a certificate-of-need law, doing so in 1979, largely in response to a federal statute that would have penalized states that did not

enact such a program. Prior to that, Missouri operated, but only sporadically, a federal Section 1122 review program, under which unapproved projects are subject to reductions in Medicare and Medicaid payments. Missouri signed an 1122 agreement in 1973, terminated it in 1975, signed a new agreement later that year, and then terminated that agreement in 1976. Yet another agreement was signed in 1979. Missouri was one of the few states to go through the period from 1976 to 1978 without either certificate-of-need or an 1122 program in operation. This may have encouraged the growth in hospital and nursing home beds in the 1970s.

The decision-making body for the certificate-of-need program is the Missouri Health Facilities Review Committee, which acts upon the recommendations of the State Health Planning and Development Agency (SHPDA), which is part of the state's Department of Social Services. Between 1979 and 1981, the first three years of the program, out of 93 applications with projected costs of $186 million, all but two were approved. Over the five years between 1979 and 1983, the Review Committee approved 94 percent of the projects before it, representing 83 percent of the proposed expenditures it considered.

The Health Facilities Review Committee has often approved projects against the recommendation of the SHPDA. In 1983, for example, of 36 substantive hospital projects reviewed, the SHPDA recommended approving 20 with a cost of $159 million. The Review Committee, however, approved 30 projects with a price tag of $270 million. In the long-term care area, the SHPDA recommended approving 5 of 14 applications, which would have cost $11 million and added 184 nursing home beds. The Review Committee, instead, approved all but one of the 14 applications, and the one disapproval was subsequently overturned on appeal. These projects have a cost of $33.6 million and will allow the construction of 1,000 additional nursing home beds. Coupled with beds approved earlier but not yet constructed, this will increase Missouri's

already high nursing home and related care facility ratio to approximately 76 beds per one-thousand elderly.

An effort to strengthen the program was made in the 1984 session of the legislature through amendments included in House Bill No. 1296. The Task Force endorses the goals and approaches embodied in that legislation. It recommends that in the next legislature the Missouri certificate-of-need statute be amended to expand membership of the Missouri Health Facilities Review Committee, to expand the scope of the program, and to tighten the standards for review. Specifically, the Task Force proposes the following:

- The Missouri Health Facilities Review Committee should be expanded from nine to fifteen members. Two members should continue to be appointed by the President Pro Tem of the Senate and two by the Speaker of the House. The remaining members should be appointed, as is now the case, by the Governor. By statute, none should be health providers. Most should represent major payors and health insurers in the state (provided the insurer's board does not have a majority of providers). These are groups that have a stake in the availability of quality health care but also have an interest in controlling the costs of such care. At least five members of the Review Committee should also be members of the State Health Coordinating Council, a separate body that is responsible for developing a state health plan.
- The scope of the certificate-of-need program should be expanded. The Task Force is concerned that some service changes, which are not subject to certificate-of-need because they are below the current threshold levels for review, can have substantial long-term impacts on use and cost. Conversion of existing beds from medical-surgical to psychiatric or chemical dependency services is one example. For this reason, it endorses

extending the scope of the certificate-of-need review to include the following service changes regardless of their cost: development of new facilities, expansion of beds, and reallocation of beds from one service to another.

- The Task Force is also concerned about how the Review Committee has exempted "donated assets." That Committee has determined that donations are not reviewable under certificate-of-need unless public funds, such as Medicare or Medicaid are required for the purchase and operation of the facility. It also has decided that a facility which indicates it has no intention of billing Medicare and Medicaid is not subject to certificate-of-need, regardless of the source of capital funding. This exception could result in substantial payments by private payors for services rendered at an exempted facility that does not treat Medicare or Medicaid patients. The Task Force believes that the exemption should be restricted to providers who make no charge to any patients, public or private.
- Applications for certificates-of-need to develop new services should be subject to competitive review based upon the relative cost and quality of alternative plans. To do this, projects for similar services need to be reviewed at the same time. This is difficult under the current certificate-of-need statute, because the review of each application must be completed within a fixed time after it is submitted. To facilitate review of similar projects, the statute should be amended to allow batching of proposed projects in a common review period.
- Criteria for need should be quantified where possible and adopted by the State Health Coordinating Council. The certificate-of-need statute should be amended to require that project review decisions be consistent with the state health plan or review criteria adopted by that Council or a written decision

prepared that explains the reasons for the variance.

- Recommendations by the SHPDA should be consistent with the state health plan and adopted criteria. Under these circumstances, the Task Force believes the recommendations of that agency should heavily influence the Review Committee. Any decisions by it to accept an application contrary to the recommendations of the SHPDA should require a two-thirds vote.

Recommendation 10: The following two topics should be the subject of further study:

- **Whether a mechanism should be established to assist institutions in financing closures and mergers.**
- **Whether institutional access to tax exempt revenue bonds should be restricted.**

The Task Force deliberated on two areas that it recommends be studied further. The first relates to the desirability of providing financial assistance to institutions, such as hospitals, that wish to downsize their capacity through closure or merger. Most hospital closures or mergers are economically feasible without a subsidy. Occasionally, however, there may be mergers that would make sense and save the community money but that face financial obstacles. These obstacles might include the need to pay off debts on the closed plant, to finance severance or pension payments to hospital workers, or to pay for transferring and maintaining patient records. A hospital that did not have sufficient funds to meet these costs might elect to continue to provide patient services. The Task Force is concerned that economically desirable mergers and closures not be hindered by such problems, and thus recommends further study of whether funds should be made available from the public and private payors in the state to help underwrite selected consolidations or closure costs. This study should include assessing the experiences of

other states, such as Michigan and Ohio, that have sought to address this issue.

The second area for study relates to tax exempt bonds. Any non-profit or public hospital can use the Missouri Health and Education Facilities Authority to issue bonds that will be repaid through hospital revenues. The advantage of their doing so is that interest on the bonds is tax-exempt and is thus lower than if the Authority were not used. The only restrictions imposed, other than the non-profit or public governance of the hospital, are that the project be financially feasible and that it have a certificate-of-need approval. The Task Force is concerned that these bonds, which receive tax subsidies from the state and federal government in the form of lower interest rates with a concomitant loss in public revenues, may serve to increase unneeded capacity or to subsidize the relocation of health facilities away from areas with a substantial indigent population. The Task Force recommends that there be further study of whether additional restrictions should be placed on this program that might, for example, limit funds to hospital projects that:

- Meet stringent definitions of need or are planned in ways that reduce unneeded capacity.
- Are within specified per square-foot construction cost.
- Provide minimum levels of care for the uninsured poor or will otherwise serve to increase financial or geographic access to hospital care.

V. DATA AND UTILIZATION

BACKGROUND

Having data that are both accurate and accessible is at the core of any cost containment strategy. For example, planning and governmental agencies require information for rational decision-making. In addition, cost containment can be promoted through voluntary restraints on the part of providers, but only if each provider knows how its price and utilization characteristics compare with its peers. Finally, in any market-oriented approach, purchasers and consumers of care must be able to compare the prices of services and the efficiency with which they are delivered if they are to make intelligent choices. For example:

- Patient cost sharing loses much of its effectiveness if consumers lack information on provider charges.
- HMOs and PPOs need information on relative price and utilization patterns in order to select providers.
- Employers, union-management trust funds, and carriers need such information if they want to encourage enrollees to use cost-effective providers.

Unfortunately, one of the characteristics of the health care-field is that data on individual providers necessary for sound decision-making is difficult to obtain.

Data on geographic areas within a state, e.g., by county or groupings of counties, is also valuable for several reasons. Studies in other states indicate that the variations in utilization for specific procedures far exceed anything that can be medically justified. For example, rates for three of the most common surgical procedures -- hysterectomy, prostatectomy, and tonsillectomy -- vary by some six-to-one among various geographic areas in Maine, Rhode Island, and Vermont. As another illustration, the rate of removal of the uterus in one city in Maine is such that a projected 70 percent of women will have the operation by the time they reach age 75, compared with only 25 percent in a city some

20 miles away.[16] Although Missouri ranks among the highest in the nation in terms of its health care costs, the results of studies conducted in other states suggest that individual areas within Missouri are likely to differ with regard both to the magnitude of the problem and to the specific procedures and diagnoses that are the most suspect. In addition, some areas may be characterized by very high admission rates and others by long lengths of stay, indicating the need for different types of cost containment measures.

PRINCIPLES

- For any cost-management strategy to be fair and effective, accurate data on individual providers must be available.
- Market-oriented strategies are particularly dependent on individual purchasers and consumers being able to compare providers in terms of their price and utilization characteristics.
- Private purchasers should take measures to curb any unnecessary utilization of health care services.
- Patient confidentiality must at all times be protected.

Recommendation 11: Legislation should be enacted to require that hospitals and physicians adopt a uniform bill. Payors should be required to accept that bill for payment purposes.

Currently, each provider decides on both the content and format of data that are displayed on a bill. This is similar to what happens in any other enterprise. What differs is the nature of involvement of third parties, such as insurance carriers and other organizations, that process the bill for payment.

The lack of uniformity, although understandable, creates two problems. First, the third-party payor is commonly not provided sufficient

[16] Phillip Caper and Michael Zubkoff. "Managing Medical Costs Through Small Area Analysis." **Business and Health.** vol. 1, no. 9, September 1984, pp. 20-25.

information with which to assess the reasonableness of either the services provided or the prices charged. At minimum, the following information is needed:

- The amount charged.
- A listing of procedures performed. These are more likely to be present for physician than for hospital services.
- The patient's diagnosis, including, where applicable, both primary and secondary diagnoses. This information is often incomplete and is essential to any legitimate comparisons among providers.

The second problem is that the information is not presented in the same format. In addition, the terminologies adopted to describe the services performed or the patient's diagnosis are not standardized. The effect is to make computer coding difficult and to increase the claims processing costs. Alternatively, the third-party payor may simply pay the bill without performing any analysis or, alternatively, impose its own requirements on the provider or the patient, thereby increasing the burden on them.

Recognizing these problems, the federal Medicare program has imposed a uniform billing requirement for services that it reimburses, and several states have enacted such a requirement for all patients. Authorizing the State of Missouri to enact such a requirement on both hospitals and physicians will reduce the claims processing and analysis burden of third-party payors. More importantly, it will also assure that payors have the data that they need to compare providers.

To ease the burden on providers, the Task Force recommends that payors be required to accept the uniform bill, unless they have specific need for additional information. Errors on hospital bills are generally acknowledged to be widespread, often because the hospital has failed to include certain charges rather than because they are billing for services not rendered. Nonetheless, some corporations and carriers report

achieving savings by auditing bills that are itemized in more detail than the uniform bill, and the proposed legislation is not intended to preclude their requesting an itemized statement.

Recommendation 12: Hospitals should calculate and publicly disclose average per case charges for up to twenty-five diagnostic categories. Similarly, physicians should be encouraged to develop and make available upon request price lists for their most common procedures. Those who purchase care should insist on such information being readily available.

For marketplace forces to be effective, sufficient information including price information, must be readily available upon which decisions may be based. Most businesses post their prices or make price lists available. Medical providers typically do not, and consumers are often reluctant to ask or may not know how to frame the question.

As a result, the Task Force recommends that physicians, hospitals, and other providers make price information publicly available. Physicians could, for example, make available a printed list of prices for the services that they most commonly perform. Dentists, podiatrists, clinical psychologists, and other practitioners who bill patients directly could also do so. It is not envisaged that the list would have more than 25 items, and it could be shorter if a small number of procedures accounted for a high proportion of a physician's practice.

Although expecting hospitals to issue price lists for individual services might be helpful, it also could be misleading. This is because the expenses associated with being admitted to the hospital reflect the combined effects of the prices for individual items of service, the number of days the patient is hospitalized, and the number of services rendered. Consequently, the Task Force recommends that hospitals post prices for the 25 highest volume diagnostic groupings of patients. The hospitals could either: (1) publish historical charge information for a recent period by

diagnostic grouping or (2) prospectively price by diagnostic grouping. The Medicare program has defined some 467 diagnosis-related groupings -- referred to as DRGs -- that it uses as a basis for paying hospitals. Hospitals are beginning to calculate their charges by DRGs, and the burden on them of complying with this recommendation should be minimal.

There is no intent that patients necessarily use the lowest priced provider, rather that they be afforded the opportunity to make choices based on better information than they now have. Furthermore, large employers and other purchasers of care should insist that providers comply with this recommendation by not entering into preferred provider arrangement with providers that fail to do so.

Recommendation 13: The State should publish, or assure that all purchasers have access to, both (1) data that compare individual providers' prices and utilization characteristics and (2) data on utilization patterns by geographic areas, such as counties or regions, that represent medical service areas.

The ease with which consumers can compare providers as well as the ability of providers to know how they stand in relation to their peers would be considerably enhanced if price and other data were collected and disseminated by a central body. For example, analyses that compared hospitals in terms of their price per DRG or physicians by specialty for commonly provided services would assist consumers and large purchasers of care in deciding which providers to favor.

In addition, as described in the Background section, geographic areas within Missouri are likely to differ widely in terms of hospital admission rates by diagnosis or diagnostic grouping as well as the rates of performance of selected procedures. Thus, it would be instructive to publish comparisons of selected indices of use among counties or aggregations of counties. Areas that rank very high for selected procedures

or causes of admission would then be further studied to determine if the high use rates appeared justified. This information would be of value in planning physician education programs or in designing health benefits. Similarly, very low use areas could be examined to help identify unmet needs. The state could itself undertake this function, or it could be performed by a different organization.

Some states, e.g., California, New York, Iowa and Illinois, have enacted laws to create data commissions. Iowa requires that all insurers provide the commission with computer tapes of data from the uniform bill, which they also have mandated. The commission plans to analyze these data and publish comparisons among both hospitals and physicians. This past year Illinois enacted similar legislation, except that claims data (with patient identifiers removed) will be submitted to its commission by the hospitals rather than by the insurers, and physician claims data will not be collected. The Task Force recommends that the experiences of Iowa, Illinois, and other relevant states be followed closely and assessed.

Recommendation 14: Private purchasers and third-party payors should ensure that they have utilization review efforts in place.

Utilization review was originated by providers concerned with the quality of care that they render. For example, hospital tissue committees have for years examined removed organs to determine whether they were, in fact, malignant. Committees have also been established to assess the causes of death for selected patients in hospitals in order to find ways to improve quality of care. More recently, however, both providers and purchasers of care have conducted utilization review with the goal of also addressing services that are either unnecessary or that could be performed in less expensive settings e.g., on an outpatient rather than an inpatient basis.

A number of approaches are possible, and each can be conducted in varying ways. The major elements of utilization review include

the following:

- Preadmission review for non-emergency patient cases. This type of review occurs prior to admission to the hospital. It focuses on whether hospitalization is necessary and whether services could be equally well performed in a less expensive setting or facility. The review process can be conducted in a variety of ways. Typically, either the patient or the doctor is responsible for notifying a medically trained person by phone or in writing of the proposed admission and describing the justification for it. Mandatory preadmission review is the single most effective utilization review measure that can be instituted.
- Prior certification of selected high-cost ambulatory services, such as certain surgical or diagnostic procedures.
- Concurrent review of hospital stays. Either prior to hospital admission or shortly thereafter a projected length of stay is assigned to each patient and periodically reassessed. This function is typically performed by a nurse who works under the direction of a physician. The nurse may also review the services provided the patient during the stay and assist in discharge planning, including promoting and coordinating the use of home health services after discharge.
- Profiling both hospitals and physicians after services have been rendered to spot patterns of potential over- or under-use.

A number of large employers in Missouri have contracted for utilization review. In addition, the St. Louis Area Business Health Coalition is mounting a major multi-employer initiative. Several large corporations in other states report very significant reduction -- as high as 30 percent --in hospital use as a result of a utilization review program.[17]

[17] Andrew Webber and Willis Goldbeck. "Utilization Review." Peter Fox et. al. eds. **Health Care Cost Management.** Ann Arbor, MI: Health Administration Press, 1984.

In light of the very high use of hospitals in Missouri, the Task Force recommends that all purchasers consider initiating utilization review programs. The Task Force also notes that the targeting of such programs, such as to particular diagnoses or providers, can be facilitated by the ready availability of data, as set forth in Recommendations 11-13.

Recommendation 15: Legislation should be enacted to protect the confidentiality of written peer review records.

On September 11, 1984, the Missouri Supreme Court ruled that written hospital peer review records must be made available to a plaintiff upon request prior to trial in a malpractice suit (**Chandra v. Independence Sanitarium Hospital, et. al.**). Underlying the majority opinion was the argument that peer reviewers' existing immunity from prosecution amply guarantees that the peer review function can be properly performed in Missouri, despite the possibility of disclosure of peer judgments in the malpractice litigation process.

The Court's opinion has thrust Missouri into a debate that has raged in the courts and legislatures of many jurisdictions since the 1970 landmark federal ruling in **Bredice v. Doctor Hospital, Inc.** The issue in that case involved a trade-off between two conflicting objectives:

- Permitting individuals who believe that they have been injured by the medical-care system to gain access to written peer-review records.
- Making the peer-review process confidential in order to promote an open and frank discussion among physicians, all of whom participate in such a process on a voluntary basis.

The **Bredice** opinion sided with the hospital. It contains the following statement:

> "Confidentiality is essential to effective functioning of these staff meetings.... Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's

> suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit. The purpose of these staff meetings is the improvement, through self-analysis, of the efficiency of medical procedures and techniques... The value of these discussions and reviews in the education of the doctors who participate... is undeniable. This value would be destroyed if the meetings and the names of those participating were to be opened to the discovery process."

The Task Force believes that the quality assurance process requires vigorous, unfettered, and critical peer analysis of physicians' and hospitals' activities and procedures. Indeed, the **Chandra** decision is already suspected of having a chilling effect on the willingness of physicians to review each other's medical practices. Thus, the Task Force recommends that state law be modified to protect the confidentiality of written peer review records. The exact boundaries of this privilege should be determined during the legislative development process.

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APPENDIX
List of Sources for Figures

Figure 1: Calculated from:

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Figure 9: Missouri Center for Health Statistics. **Missouri Hospital Profiles 1983.** Table 10. Jefferson City, MO: Missouri Department of Social Services, May 1984.

Figure 10: Missouri Center for Health Statistics. **Missouri Hospital Profiles 1983.** Table 9. Jefferson City, MO: Missouri Department of Social Services, May 1984.

Figure 11: Data prepared by Missouri Hospital Association based on American Hospital Association's Annual Survey of Hospitals: 1981-1983.